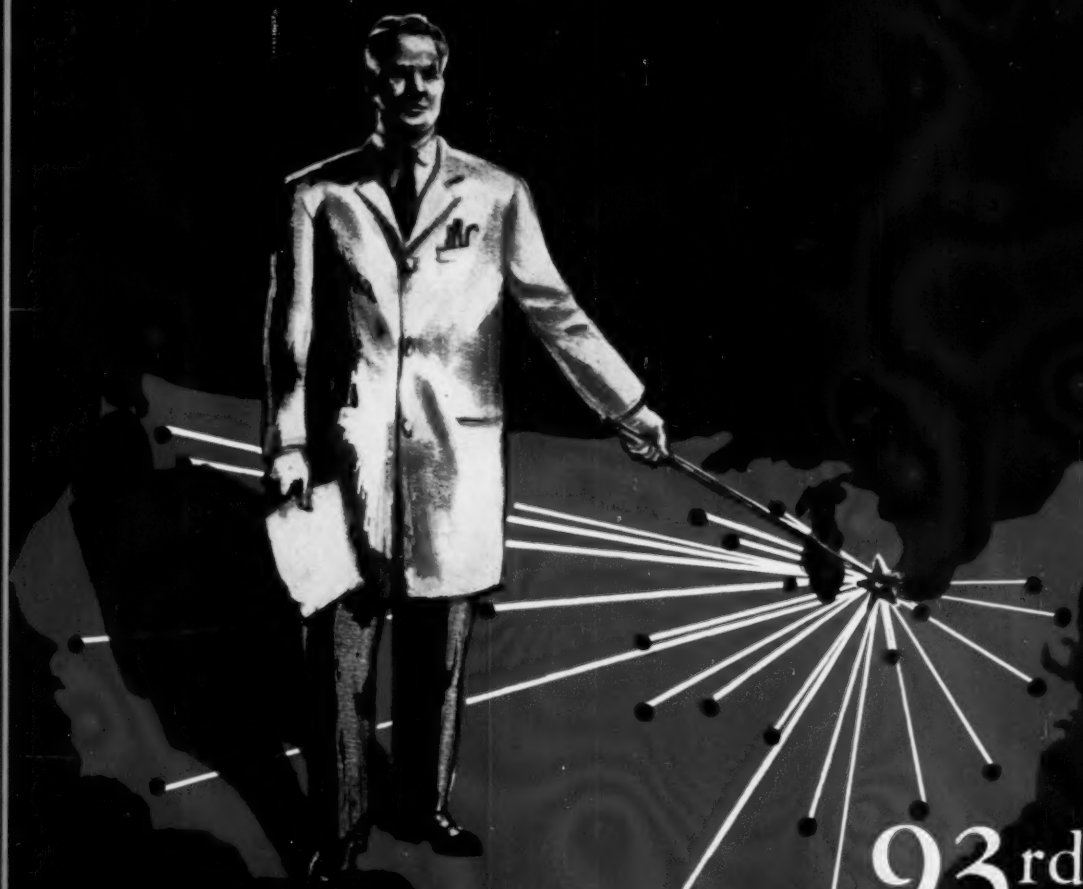
The Journal

Michigan

STATE MEDICAL SOCIETY

July, 1958
Volume 57
Number 7



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of the Michigan State Medical Society

VOLUME 57 JULY, 1958 NUMBER 7

Contributors to This Issue

MANUEL FERNANDEZ, M.D.

C. PAUL HODGKINSON, M.D.

WILLIAM B. KOUNTZ, M.D.

BERNARD LEVINE, M.D.

J. C. RINGENBERG, M.D.

EDWARD C. THOMPSON, M.D.

F. W. WILLIAMS, M.D.

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of the Michigan State Medical Society

VOLUME 57 JULY, 1958 NUMBER 7

Office of Publication
2642 University Avenue
Saint Paul 14, Minnesota

Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Assistant Editor
L. J. BAILEY, M.D.
Medical Concourse, Northland Center, Detroit 35, Michigan

Secretary and Business Manager of THE JOURNAL
L. FERNALD FOSTER, M.D.
441 E. Jefferson, Detroit, Michigan

Executive Director
WM. J. BURNS, LL.B.
606 Townsend Street, Lansing 15, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscription should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone Ivanhoe 5-7125.

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $6.00; single copies, 60 cents. Additional postage; Canada $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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Ninetieth Anniversary

Wayne State University College of Medicine Alumni Association held its ninetieth alumni reunion and clinic program on May 7, 1958, in Detroit. A daytime and evening program started with registration at 8:00 a.m. All programs were at the Fort Shelby Hotel.

MEMBERS OF THE CLASS OF 1908

(Left to right) Henry L. Ulbrich, M.D., Clayton J. Ettinger, M.D., J. Milton Robb, M.D. (valedictorian), John S. Van Loon, M.D., and William J. Cassidy, M.D.

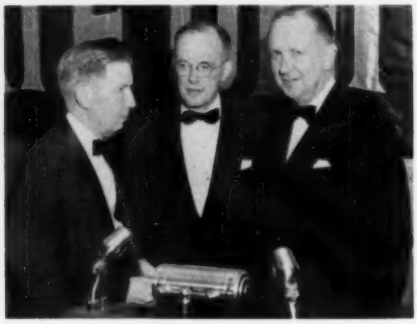
At the annual business meeting, Clarence I. Owen, M.D., was selected as president-elect. The program was a surgical symposium on "Biliary Tract Disease." Participants were Sol G. Meyers, M.D. Detroit, Michigan, Clinical Professor of Medicine, Wayne State University College of Medicine; James E. Lofstrom, M.D., Detroit, Michigan, Professor and Chairman, Division of Radiology, Wayne State University College of Medicine; Alfred M. Large, M.D., Detroit, Michigan, Assistant Professor of Clinical Surgery, Wayne State University College of Medicine.

The first paper presented, "State of the Nation's Health and National Health Problems," by Leonard A. Scheele, M.D., former Surgeon-General of the United States Public Health Service, was a careful study of health information, improvements, and trends.

The second paper, "Medical Writing" by Jonathan Forman, M.D., Editor of the *Ohio State Medical Journal*, was primarily a treatise on medical writing its importance, and each doctor's need to do medical writing himself.

The luncheon following the morning program was through the courtesy of Parke, Davis & Company.

The afternoon program included two papers: "Cancer Detection in the Office of the Generalist," presented by John S. DeTar, M.D., Milan, Michigan, past president, American Academy of General Practice; "Acute Interstitial Pancreatitis —Fact or Fiction," presented by Carl A. Moyer, M.D. St. Louis, Missouri, Bixby Professor of Surgery, Washington School of Medicine. These papers were followed by a panel discussion on "Care of the Diabetic Pregnant Patient." The panel consisted of Robert B. Leach, M.D., Detroit, Assistant Professor of Medicine, Wayne State University College of Medicine; George C. Thosteson, M.D., Detroit, Associate Clinical Professor of Medicine, Wayne State University College of Medicine; and Harold Fachnie, M.D., Detroit, Assistant Professor of Obstetrics and Gynecology, Wayne State University College of Medicine.



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(Left to right) Lawrence Pratt, M.D., Gordon B. Myers, M.D., and Leonard A. Scheele, M.D.

Trustees of the Medical Library Fund, Inc., held their annual meeting following the general meeting.

A reception at 6:15 was followed by the annual Alumni Reunion Banquet, at which Clarence I. Owen, M.D., was toastmaster. Greetings from the College were given by Dr. Gordon H. Scott. Recognition was given the class reunion groups and members of the class of 1958 were introduced.

Alumni awards were presented by Don W. McLean, M.D., honorary president, Medical Alumni Association. The Medical Annual Sophomore

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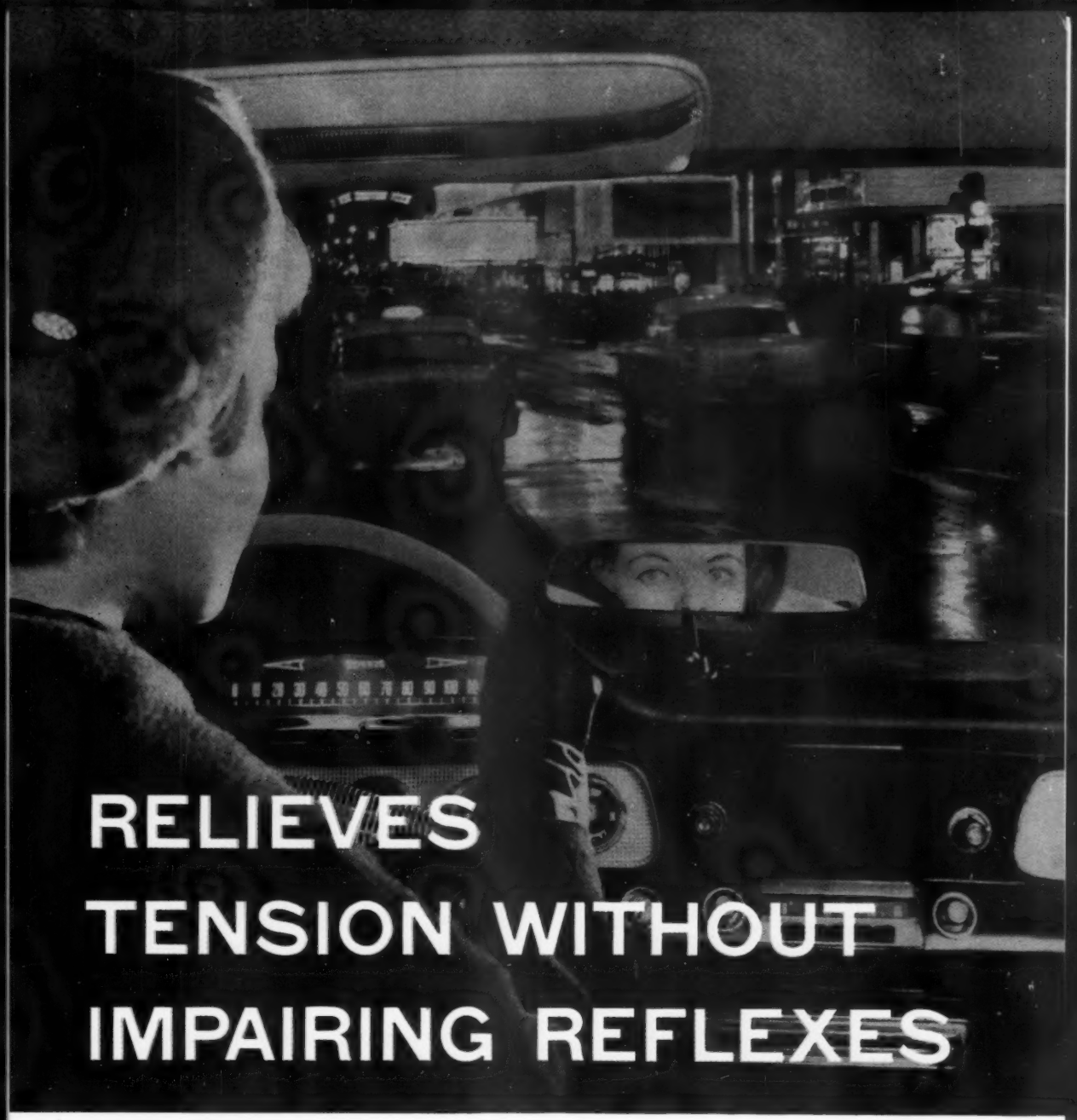

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(Continued from Page 930)

Award was given to Ronald Seltzer, and the Medical Alumni Senior Scholarship Award was presented to Jerry R. Croteau.

The Class of 1908 Golden Anniversary Diplomas were presented by Irwin W. Sander, M.D., Class of 1929, with the response by James Milton Robb, M.D., Class of 1908. Only ten members of this class are living. Those attending were: Clayton J. Ettinger, M.D., Detroit; J. Earl McIntyre, M.D., Lansing; Daniel J. O'Brien, M.D., Lapeer; Henry W. Paddell, M.D., London Ontario; James Milton Robb, M.D., Detroit; John S. Van Loon, M.D., Detroit; and Henry L. Ulbrich, M.D., Grosse Pointe. Those unable to attend were William J. Cassidy, M.D., Detroit; Fred H. Cole, M.D., Detroit, and John H. Elias, M.D., Glouster, Ohio.

The ceremonial presentation consisted of a review of each man's medical history, condensed but interesting. Following this was the presentation of the Distinguished Service Citations given by Lawrence A. Pratt, M.D., President of the Medical Alumni Association. Gordon B. Myers, M.D., of the faculty, was cited for outstanding teaching service over the years. Leonard A. Scheele, M.D., of the Class of 1934, was cited for his long years of service in public health, and for almost nine years as Surgeon-General of the United States Public Health Service.

Dr. Reginald Luxton, of Manchester, England, gave a very challenging address, "A Prescription for Health." The final part of the program was the installation of the new president, Theodore I. Bergman, M.D., of the Class of 1932. The Medical Alumni Association gathering has been an outstanding feature in Michigan for a great many years, and this year's assembly marked the ninetieth anniversary of the establishment of the College.

THE DOCTOR EXPLAINS TO THE PATIENT

Detailed explanations of the basic elements of an illness, given unhurriedly and sympathetically, have become additional "tools" of the modern doctor. Discussions between the doctor and his patient regarding the probable duration of the illness, how therapy is expected to be effective, and its effect on the patient's manner of living—serve several purposes. Misunderstanding is avoided, and the patient's fullest cooperation is more likely to be obtained; anxiety, an almost constant factor in organic illness, is alleviated; a good physician-patient relationship is established by the physician's obvious interest; the doctor's sympathy, understanding, and patience become powerful therapeutic agents; and severe nervous reactions are less likely to occur.

"Such an approach may require an attitude different from what the physician learned in medical school, when emphasis, for the most part, was on the particular ailment rather than on the patient with the ailment," the article points out. "Today, patients take scientific diagnosis and treatment for granted, want personalized attention, and expect consideration of themselves as individuals."—*Therapeutic Notes.*

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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Michigan Doctors Active in National Science Fair

SCENE OF AWARDS LUNCHEON

The American Medical Association was host at the awards luncheon held in the Industrial Mutual Auditorium, Flint, Michigan, with George W. Slagle, M.D., presiding.

Offering their congratulations to the winners of the American Medical Association's top honors in the basic medical science exhibits entered in the National Science Fair in Flint, May 7-10, were Otto J. Preston, M.D., chairman of the Fair's executive committee and immediate past president of the Genesee County Medical Society; Clayton K. Stroup, M.D., president of the county society, and George W. Slagle, M.D., president of the Michigan State Medical Society.

The winners were David R. Brown, fifteen, Minneapolis, Minnesota, for his exhibit on "Humeral Transplants," and Clare L. Chatland, sixteen, Missoula, Montana, for her work with hypersensitized mice. The AMA awards consisted of a citation and invitation to exhibit their work at

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AMA SCIENCE AWARD WINNERS RECEIVE CONGRATULATIONS

(Left to right) Otto J. Preston, M.D., chairman of Science Fair executive committee; David R. Brown, Minneapolis; Clayton K. Stroup, M.D., president, Genesee County Medical Society; Clare L. Chatland, Missoula; George W. Slagle, M.D., president, Michigan State Medical Society.

when eating moves outdoors . . .

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the 107th annual meeting in San Francisco, June 23 to 27.

Doctor Preston presented the citations at a special AMA luncheon, and Doctor Slagle acted as master of ceremonies. More than 820 students, teachers, regional science fair sponsors, and press and medical representatives attended in the Industrial Mutual Auditorium. Doctor Stroup was one of the honored guests.

Clare's and David's exhibits were chosen from a field of 281 entries from forty-one states, the District of Columbia, Alaska, Hawaii, Germany, and Japan by an AMA judging committee headed by Dr. Alphonse McMahon, St. Louis; Dr. Stanley P. Reimann, Philadelphia; Dr. Henry R. Viets, Boston, and Dr. Thomas G. Hull, Chicago—chairman and members, respectively, of the AMA Council on Scientific Assembly.

The annual Ninth National Science Fair, sponsored by Science Clubs of America, Washington, D. C., was the largest and most successful in history. The exhibits were viewed by more than 30,000 students and adults in the Ballenger Field House on the Flint Junior College Campus, and all previous attendance records were broken. The AMA awards, which were presented for the third consecutive year, are the annual highlight capping the medical profession's program to encourage talented students to study the medical sciences. Next year, the Fair will be held in Hartford, Connecticut, and the following year in Indianapolis, Indiana.

COMMITTEE STUDIES BASIC PROGRAMS

One of the first projects of the Committee to Study AMA Objectives and Basic Programs will be to send out a questionnaire inviting suggestions and criticisms of the Association. This questionnaire will be based on the following four points which were listed by the House of Delegates when the committee was organized last December: (1) redefining the central concept of AMA objectives and basic programs; (2) placing more emphasis on scientific activities; (3) taking the lead in creating more cohesion among national medical societies, and (4) studying socioeconomic problems.

The questionnaires will be sent to not only state and county medical societies, specialty groups and other national medical organizations but also to a probability sample of more than 3,000 physicians chosen systematically from the new AMA directory. The latter sample will include both AMA members and nonmembers.

Members of the committee include: Drs. Lewis A. Alesen, chairman, Los Angeles; Thurman G. Givan, Brooklyn; Milford O. Rouse, Dallas; James Z. Appel, Lancaster, Pennsylvania; Hugh H. Hussey, Washington, D. C., and Raymond M. McKeown, Coos Bay, Oregon.

Heart Beats

MHA EXECUTIVE DIRECTOR TO JOIN TEXAS HEART ASSOCIATION

Ernest T. Guy, Detroit, Executive Director of the Michigan Heart Association for the past five and one-half years, has been appointed Executive Director of the Texas Heart Association with headquarters in Houston, it was announced recently. Mr. Guy was the first layman to become MHA Executive Director, the position having been filled by medical doctors during the Association's first three years of existence.

Mr. Guy joined the Michigan Heart Association on May 15, 1950, as Public Relations Director and was named Executive Director on January 1, 1953. In October, 1952, he released to the nation's press the startling announcement concerning the first successful use of a "mechanical heart" on a human patient which maintained blood circulation while surgeons operated on the living heart. The "mechanical heart" was developed by a medical-engineering team headed by F. D. Dodrill, M.D., Detroit, current MHA President, and it was rated as one of the top ten scientific developments of 1952.

During Mr. Guy's tenure as Executive Director, the Michigan Heart Association has grown from a small office in Detroit with two employes in 1953 to twenty-two employes at present with regional offices located in four major areas of the State. The Association's income has increased 335 per cent during the same period of time.

EARLY REGISTRATION URGED FOR SCIENTIFIC SESSIONS OF AMERICAN HEART ASSOCIATION

As an inducement to early registration for attending the American Heart Association's Annual Scientific Sessions in San Francisco, October 24-26, all physicians who register prior to the meeting will receive for the first time this year an advance complimentary program containing abstracts of the proceedings. The program will be sold for $1.00 at the meeting. Registration and accommodation forms are now available from the Association, 44 East 23rd Street, New York 10, N. Y.

Following is a tentative schedule of the program:

Friday, October 24.—A morning session on genetics will be presented jointly by the Heart Association and the American Society for the Study of Arteriosclerosis. The Society is holding its Annual Meeting to coincide with the AHA Scientific Sessions this year for the first time. Concurrent sessions of general interest to physicians will also be held Friday morning under sponsorship of the AHA Councils on Circulation and on Cardiovascular Surgery.

A session sponsored by the Association's Council on Rheumatic Fever and Congenital Heart Disease will be held Friday afternoon, as will a symposium conducted jointly by the AHA Council on Circulation and the Microcirculatory Conference. Friday evening's session will be on the subject of "Instrumental Study of the Heart and Circulation."

Practicing Physicians' Session.—An all-day session for physicians in general practice and for internists will be held concurrently on Friday under sponsorship of the Council on Clinical Cardiology. Presented initially last year, it is essentially a presentation of clinical problems in cardiovascular disease and has again been classified by the American Academy of General Practice as acceptable for Category II credit for Academy members.

Saturday, October 25.—Scheduled for Saturday morning are a session on Applied Cardiovascular Research; the Lewis A. Conner Memorial Lecture by John H. Gibbon, Jr., M.D., Professor of Surgery, Jefferson Medical College, Philadelphia, on "Maintenance of Cardio-Respiratory Functions by Extracorporeal Circulation;" the George E. Brown Memorial Lecture by Lewis Thomas, M.D., Professor and Chairman, Department of Pathology, New York University College of Medicine on "The Role of Hypersensitivity in Cardiovascular Disease and the presentation of the Albert Lasker Award of the American Heart Association for cardiovascular research.

On Saturday afternoon, joint panels on "Emotional and Endocrine Aspects of Cardiovascular Disease" and "Effects of Hemodynamics and Vascular Injury" will be presented in conjunction with the American Society for the Study of Arteriosclerosis.

Sunday, October 26.—The schedule for Sunday morning includes simultaneous sessions to be con-

(Continued on Page 940)

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1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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EARLY REGISTRATION URGED FOR AHA SESSIONS

(Continued from Page 938)

ducted by the Councils on Clinical Cardiology, High Blood Pressure Research, and Basic Science. A special program, "Rewards of Research," designed to interest physicians as well as laymen will be held Sunday afternoon, as will the program on "Prevention of Rheumatic Fever." The Association's Annual Dinner is scheduled for Sunday evening.

In addition, the program will include the showing of a number of medical motion pictures. Also, a section of scientific and industrial exhibits will be provided. Plans are under way to present an award for the outstanding scientific exhibit on display.

The Annual Meeting of the Assembly to review national policies and activities of the Association will be held on Monday, October 27, and Tuesday, October 28. The Assembly convenes on Monday morning to hear a keynote address by Dr. William P. Shepard, 2nd Vice President, Health and Welfare Division, Metropolitan Life Insurance Company.

Six Assembly Panels will be in session on Monday. The full Assembly, national delegate body of the Heart Association, will meet Tuesday morning to review Panel recommendations and to elect officers and Board members of the Association.

SCIENTIFIC SESSIONS IN HAWAII TO FOLLOW AHA MEETING

Following the 31st Annual Scientific Sessions of the American Heart Association in San Francisco, October 24-26, the Hawaii Heart Association will conduct a post-meeting tour which includes two days of cardiological scientific sessions in Honolulu on October 31 and November 1. Arrangements to participate may be made through H. Douglas Chisholm, Associate Director American Heart Association, 44 East 23rd Street, New York 10, N. Y., or directly through the American Express Company, 65 Broadway, New York, N. Y.

PROCEEDINGS OF HYPERTENSION MEETING PUBLISHED

The Proceedings of the Annual Meeting of the American Heart Association's Council on High Blood Pressure Research, which contain up-to-date symposium on mineral metabolism as related to arterial hypertension, are now available. The Council met in November, 1957.

The 109-page illustrated volume includes discussions by authorities on such subjects as *"The Relationship of Sodium and Water Ratios to Hypertension," "Exploration of the Renal Excretory Mechanism with Radioactive Sodium and Potassium," "Chronic Sodium Chloride Toxicity and the Protective Effect of Potassium Chloride."*

Also included in the volume are reports on the current status of surgical treatment, chemotherapy, epidemiology of hypertension and on instrumental techniques.

The volume, sixth in a series on Hypertension based on the Council's annual meetings, is obtainable through the American Heart Association, 44 East 23rd Street, New York 10, N. Y., or through local Heart Associations at $2.50 a copy. A special pre-publication rate of $2.00 a copy will be given for orders received before June 1, 1958.

APPLICATIONS FOR RESEARCH SUPPORT NOW BEING INVITED BY AMERICAN HEART ASSOCIATION

Applications by research investigators for support of studies to be developed during the fiscal year beginning July 1, 1959, are now being accepted by the American Heart Association.

The deadline for Research Fellowship applications and Established Investigatorships is September 15, 1958. Applications for Grants-in-Aid must be made by November 1, 1958.

Fund for Association-supported research in the cardiovascular field are provided by public contributions to the Heart Fund. At least half of all funds received by the American Heart Association's National Office are allocated to research. Almost $31,500,000 has been allocated for research support by the Association and its state and local affiliates and chapters in the past 10 years.

TWO NEW LEAFLETS

The personal, human qualities of medical practice are emphasized in two new American Medical Association leaflets designed for the general public. The first, "Do *You* Like to Make Decisions?", states that the physician applies the "skill of his profession with the art of his understanding" in prescribing a specific treatment suited to the patient's individual needs. In selecting a particular treatment, the doctor is guided by his knowledge of the patient and his faith in his own judgment. The second leaflet—"The Fifth Freedom"—points out every American's basic right to choose not only where he will live or the church he will attend but also the physician in whom he has the greatest confidence. Free choice and mutual understanding are essential to the formation of a good doctor-patient relationship.

Both pamphlets have been distributed in recent months to state and county medical societies for distribution at local fairs and similar public gatherings.

You and Your Business

RADIATION HAZARDS

The reduction of radiation hazards whenever practicable and the facing up to those that must be tolerated was advocated recently by C. W. Shilling, M.D., Deputy Director, Division of Biology and Medicine, Atomic Energy Commission, at a meeting of occupational health specialists in Atlantic City, New Jersey, April 22, 1958.

Dr. Shilling said:

"Obviously the risk from the ever-present background of radiation has to be taken. We cannot get away from it, for even if we lived in a balloon, thus escaping radiation from the earth's crust, we would receive additional radiation from cosmic rays. Also, it seems obvious that we must take our chances with the medical use of the x-ray and by-products of atomic energy, both for diagnosis and treatment. I would urge, however, that the roentgenologist become thoroughly familiar with this problem and use x-ray as sparingly as possible.

"The next question we must face and answer is, *must we continue to live with radioactive fallout?* To this, the answer is 'yes,' for we must continue testing of the various types of nuclear weapons not only to study their characteristics but also, and perhaps more importantly, to study ways and means of protecting populations from their effects, should they ever be used in warfare. We must gamble with the probability of radiation damage to a few individuals in order to secure the survival of the total society."

Concerning atomic powers to be generated by nuclear reactors, Dr. Shilling said that the risk of accidental release of radioactive contamination is extremely low. He pointed out that the atomic energy program has made an excellent safety record in its operations to date and that there is every reason to believe that, under the safeguards in effect, this good record will continue as the atomic power industry develops. Dr. Shilling observed that the cheaper atomic power would undoubtedly revolutionize the civilization of many areas of the globe and that better living conditions would definitely follow. The incalculable benefits derived from isotopes were also described by Dr. Shilling. He said, "It has been estimated that the use of isotopes in industry already is resulting in cost savings of $295 million to $485 million annually. This does not count the enormous advancement of the frontiers of knowledge through the use of isotopes in research, nor does it count the value to humanity in the diagnosis and treatment of disease."

Dr. Shilling stated that the National Academy of Sicences report indicates that the amount of radiation to the gonads from fallout, if testing is continued at the level of the past five years, probably will amount to 0.1 roentgen for the average person in the United States during his reproductive lifetime. This should be compared, he said, with the average reproductive lifetime dose to the gonads of 4.3 roentgens from natural or background radiation and 3.0 roentgens from the medical use of x-rays.

The animal experimental work of the Atomic Energy Commission, Dr. Shilling said, has indicated that, following exposure to large amounts of radiation (enormous when compared to fallout), there is an increase in the incidence of cancer, there is an aging effect, and there is definite life shortening, but this is with exposures at thousands of times greater than the average received from all fallout from 1945 to date.

With regard to genetic effects, Dr. Shilling said:

"The radiation produced by fallout from atomic weapons tests as well as from present and future peaceful applications of nuclear energy will result in additional mutations in human genes. The number of these cannot be estimated accurately at this time. At the current rate of irradiation from fallout, among the four million children born each year in the United States, perhaps from a hundred to several thousand may carry as a result of this irradiation a mutated gene. At most, a small percentage of these genes will not produce any noticeable effect in the first generation. Only slowly, over hundreds of years will the majority of these radiation-induced genes become apparent, in a few individuals at a time, usually by causing a less than normal development or functioning of the person concerned. It will be impossible to identify these individuals among the large number of similar ones, affected by genes already present in the population due to accumulated spontaneous mutations.

"No measurable increase in defective individuals will be observable at any time as the result of current weapons' tests, since the few radiation-induced defectives will not change measurably the number of about 40,000 defectives who will occur spontaneously among the four million births of each year in the United States. It may be pointed out that no significant change in the percentage of malformed children has been observed among those conceived after the war whose parents had been exposed to the atomic bombs in Hiroshima and Nagasaki."

Dr. Shilling presented the C. O. Sappington Memorial Lecture, part of the program of the Industrial Medical Association. This group, together with the American Conference of Governmental Industrial Hygienists, the American Industrial Hygiene Association, the American Association of Industrial Nurses, and the American Association of Industrial Dentists, comprises the week-long National Industrial Health Conference, which has brought together over 3,000 leading occupational health specialists. The conference is devoted to an exchange of the latest information on the control of occupational health hazards and on general health maintenance of workers.

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REBUILDING HISTORIC MACKINAC ISLAND

THE JOURNAL readers, particularly those who are interested in the Beaumont Memorial and the entire Mackinac Island restoration program, will be interested in knowing that a modern museum is being installed in the refurnished Fort Mackinac.

Highlighting the displays in the museum will be a series of six large action-filled murals painted by artist Dirk Gringhuis of Lansing. Mr. Gringhuis has been the official cover artist for the MSMS JOURNAL for the past two years.

Other color displays, including a Beaumont section, will recreate an exciting event in the Fort's 200-year-old history. The above activity has been sparked by the Mackinac Island State Park Commission under the direction of W. S. Woodfill, chairman. Dr. Eugene T. Petersen, Curator of the Michigan Historical Museum in Lansing, is director of the project.

Other associations have been following the lead of the Michigan State Medical Society and the Beaumont Memorial Foundation in restoration of this historic Island to its grandeur of the early Eighteen hundreds. For example, the Michigan Society of Architects presently is restoring the Biddle House on Market Street.

Appropriately, the Beaumont Memorial Foundation is expanding its medical museum in the Beaumont Memorial guided by the dedicated efforts of Otto O. Beck, M.D., of Birmingham, past president of the State Society and President of the Foundation.

It is interesting to note that the members of MSMS again have set a pattern—by their sponsorship and maintenance of the Beaumont Memorial—which bids fair to succeed in an over-all rebuilding and restoring of all the historic "shrines" on Mackinac Island.

TRAFFIC ACCIDENTS

Human failure, rather than the condition of road or vehicle, is the largest factor in causing traffic accidents. Poor judgment, slow reaction time, faulty mental attitudes and physical and emotional disabilities are basically responsible for most accidents.

Seward E. Miller, M.D., director of the Institute of Industrial Health at the University of Michigan, speaking at the conference on Medical Aspects of Highway Safety, held at the University of Michigan Medical Center, predicted that one person in every ten will be killed or injured in a motor vehicle accident in the next fifteen years. Dr. Miller termed this "one of the nation's largest unsolved health hazards."

The effect of the mounting death rate (40,000 killed in 1957) is that conscientious people are coming to family physicians to learn whether they have the physical and emotional ability to meet the demands of day-to-day driving.

He urged the 150 physicians and specialists in his audience to measure the driving ability of these patients with six major questions:

1. Is the patient likely to suffer excessive fatigue?
2. Is he apt to lose consciousness, or become confused?
3. Are his vision and hearing adequate to cope with today's high-speed highways?
4. Does he have the physical and mental ability to manipulate the controls of the vehicle?
5. Does he have absolute emotional control of himself or does he show signs of anti-social behavior?
6. Is he subject to temporary impairment of physical and mental abilities because of drugs, alcohol, infection or medical treatment?

Dr. Miller pointed out that patients with convulsive disorders, heart disease and certain forms of diabetes, risk their lives every time they get behind the wheel of an automobile.

Other dangerous disabilities result from hypertension, particularly through complications in the brain, kidney, heart or eyes. Any form of dizziness or vertigo also disables a driver, as does Ménière's disease until it is controlled.

The great bulk of personal injury accidents occur among drivers who are only involved once in a collision. The small minority of drivers who get into trouble repeatedly are special cases, often characterized by low intelligence, youthfulness or supreme egotism.

MICHIGAN HEALTH COUNCIL MEMBERSHIP SPIRALING HIGHER

Thirteen new voting members, two associate members and ten new chapters were welcomed into membership of the Michigan Health Council at a spring dinner meeting held May 12 at Kellogg Center, Michigan State University.

A meeting of the co-sponsors for the twelfth annual Michigan Rural Health Conference was conducted after the membership ceremonies.

The thirteen new voting members of the Michigan Health Council are the Michigan League for Nursing, Michigan State Dental Assistants, Michigan Practical Nurses Association, Michigan Department of Agriculture, Michigan Chapter —National Multiple Sclerosis Society, Michigan State Association of Supervisors, Michigan Chapter of the American Physical Therapy Association, Michigan State Association of Accident and Health Underwriters, Michigan State Association of Life Underwriters, Michigan Department of Mental Health, Consulting Engineers of Michigan, Michigan Office of Hospital Survey and Construction and Michigan Office of Vocational Rehabilitation.

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MICHIGAN HEALTH COUNCIL

(Continued from Page 944)

Associate Members Added

The Michigan National Bank and Michigan Associates (a large Lansing consulting engineering firm) were awarded recognition as associate members. An associate is a new classification for individuals or corporations which are not health organizations but have an interest in the progress of the Michigan Health Council and its aims and purposes.

The ten new chapters of the Michigan Health Council which received certificates were the Algoma Health Council, Clarence Township Health Council, Hamtramck Inter-Agency Organization, Maple Grove Community Council, Haslett Community Council, Port Huron Junior Chamber of Commerce, Warren Community Council and Wyandotte Health Council. The term "chapter" is a new designation for community health councils which has been adopted by the Finance and Membership Committee and approved by the Board of Trustees of the Michigan Health Council.

Expansion Anticipated

There are now fifty-eight voting members, two associate members and eighty-four chapters. Hugh W. Brenneman, Secretary of the Michigan Health Council, announced that five more applications for voting memberships have been received. He indicated that with the present progress in membership, the Board of Trustees hoped to have ninety voting member organizations and associates as well as 100 Health Council chapters by the end of 1958. This would enable the Health Council to expand greatly its programs and projects to Michigan communities.

J. K. Altland, M.D., president of the Michigan Health Council, announced that during the year, much emphasis will be given to "health careers" through the weekly television programs of the Councils and to the expansion of the M.D. Placement Program.

During the membership ceremonies, Marvin L. Niehuss, Health Council vice president; H. B. Zemmer, M.D., medical advisor, and Mr. Brenneman gave inspirational talks on the past, present, and future activities and plans of the Health Council.

Conference Date Set

The dates of the twelfth annual Michigan Rural Health Conference have been set for April 8 to 9, 1959, at the Kellogg Center, Michigan State University, by the co-sponsors at their business meeting following the dinner program.

Harry A. Towsley, M.D., is general chairman for the 1959 Conference. He stated that the 1958 Conference had been hailed as the finest health conference for professional and lay people ever held in Michigan and had received nationwide publicity on many of the talks given by the fifty-six speakers on the conference program. Doctor Towsley also read many suggestions received for subjects, topics and participants for next year's program and urged that members as well as nonmembers of the Michigan Health Council send in suggestions.

John A. Doherty, executive secretary, said he hoped that the 1959 Conference will draw an attendance of close to 1,000 rural and urban residents as well as representatives from health organizations and high school students interested in health careers.

HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of May 14, 1958

- **Progress Report on New MSMS Headquarters Building.** Architects Yamasaki and Jarrett will have preliminary plans ready for presentation of The Council in July; the final plans will be presented to The Council in September, for referral to the House of Delegates on September 27, 1958.

  The Bruce Publishing Company of St. Paul, Minnesota, long time publishers of JMSMS, offered to contribute $1000.00 for the new MSMS building, which generous offer was accepted with high thanks.

- **New Blue Shield Contract.** Michigan Medical Service Vice President Jay C. Ketchum reported that on May 14, the Insurance Department had approved the new contract which will be publicized as of June 1, 1958. The Executive Committee of The Council instructed that every MSMS member be sent by mail full information and a specimen copy of the new Blue Shield contract.

- **President G. W. Slagle, M.D.,** Battle Creek, reported on his official attendance at meetings of the Ohio State Medical Association in Cincinnati, of the Medical Society in the State of Wisconsin in Milwaukee, at the National Science Fair in Flint; he urged more active participation in this last activity (MSMS this year joined with the Genesee County Medical Society in underwriting the cost of the souvenir program).

  The suggestion that the two winners of the AMA Awards at the National Science Fair be invited to one of the Michigan Delegates' Breakfasts at the forthcoming AMA Annual Session in San Francisco was approved.

- **Appointments:** Dale L. Kessler, M.D., Grand Rapids, was appointed as MSMS Representative to the North Central District Blood Banks

(Continued on Page 950)

Investigator

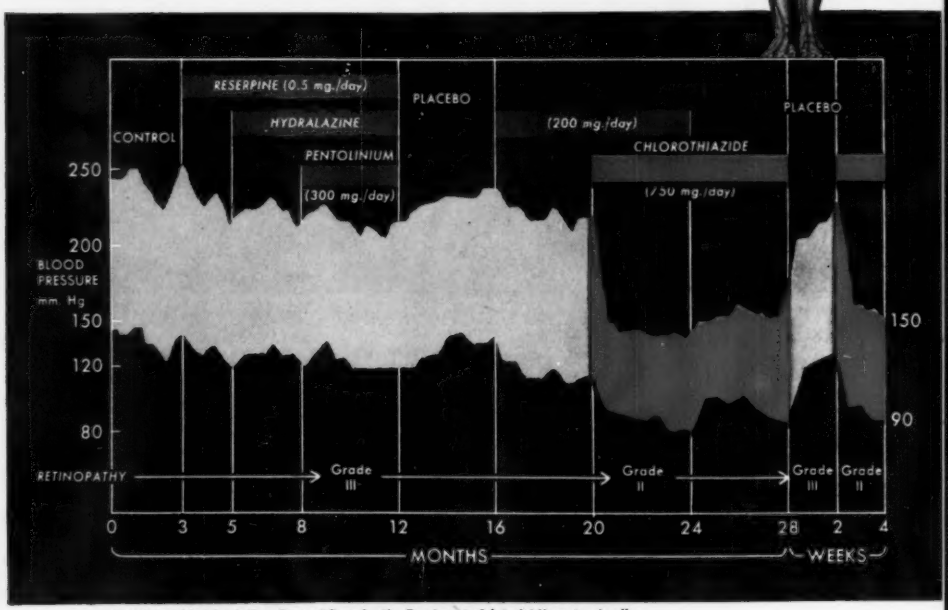
after investigator reports

Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 946)

Clearing House; T. Sid Conover, M.D., of Flint, was appointed as a member of Committee to Arrange Program for State Board of Alcoholism; H. E. Cope, M.D., Lansing, was appointed as member of the 1959 Michigan Clinical Institute Committee on Arrangements; L. Fernald Foster, M.D., Detroit, and R. L. Novy, M.D., Detroit, were nominated to the Michigan Hospital Service Medical Advisory Committee; I. A. LaCore, M.D., Pontiac, was appointed as MSMS Representative to the Fifth Annual Conference of Mental Health Representatives to be held in Chicago.

- **Liaison Study Committee on Hospital Staff Payments by Michigan Medical Service.** A committee requested by the MMS Board was appointed: Muir Clapper, M.D., Detroit; B. E. Brush, M.D., Detroit; R. B. Nelson, M.D., Ann Arbor; H. C. Mack, M.D., Detroit; Julian E. Priver, M.D., Detroit; O. B. McGillicuddy, M.D., Lansing; John R. Pedden, M.D., Grand Rapids; J. W. Rice M.D., Jackson, and C. K. Stroup, M.D., Flint.

- **Legal Counsel Lester P. Dodd** presented opinions (a) re legality of paying a Blue Shield claim to a physician subscriber who has either treated himself or a member of his immediate family; (b) re electrocardiogram being interpreted by M.D.'s for non-medical laboratories; (c) re term "unprofessional conduct."

- **Financial report for the month** was presented, studied and approved; bills payable were given study, approved and payment authorized.

- **1959 Michigan Clinical Institute Television Program Committee** was appointed: Wm. S. Reveno, M.D., Detroit, Chairman; E. A. Osius, M.D.; C. G. Johnson, M.D.; B. E. Brush, M.D.; D. W. Myers, M.D.; D. H. Kaump, M.D., of Detroit and Robert A. Reath, Philadelphia, Advisor. Providence Hospital, Detroit, was chosen as the site for beaming the 1959 color television program during the MCI, March 10-11-12-13, 1959.

- **Report from L. A. Drolett, M.D., MSMS Representative** to the Chicago meeting on Uniform Hazardous Substances Act, was approved with thanks.

- **Public Relations Counsel's Report** included (a) progress on MSMS Seal of Assurance Campaign; (b) legislative bills pending; (c) invitation to MSMS to appoint representative to Legislative Advisory Committee—the Executive Committee of The Council appointing A. H. Hirschfeld, M.D., Detroit; (d) progress report on Michigan Association of Professions; (e) People's Community Hospital Authority; the public relations counsel was authorized to meet with the chiefs of staffs in these hospitals to obtain information and study the problems; (f) the MSMS Exhibit was authorized to be shown at the Michigan State Fair in Detroit, at the Ionia Free Fair, and at the Saginaw County Fair; (g) E. S. Oldham, M.D., Councilor for the eighth district, was authorized to attend the Michigan Practical Nurses Association annual convention in Saginaw as MSMS representative.

- **Committee Reports.** The following were considered: Maternal Health Committee, meeting of February 6; Rural Medical Service Committee, April 10; Permanent Conference Committee, April 16; Study Committee on Prevention of Highway Accidents, April 17; Planning Committee for Officer's Night Dinner Dance, April 22; Rheumatic Fever Control Committee, May 7; Committee on Committees, May 13; Arbitration Committee, May 25; VA Home-Town Medical Care Program Fee Schedule Committee, April 15.

- **Michigan Health Commissioner A. E. Heustis, M.D.,** presented matters of mutual interest re the Department budget; poliomyelitis; nursing homes; TPCF Testing; and radiation policy.

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PR REPORT

ORIGINS OF SELF REGULATION IN MEDICINE: Part V

By Gaylord S. Bates, M.D.

The history of American medicine with respect to regulation has reproduced in 300 years the European experience of 2000 years. It began with uncontrolled practice by whoever wished to call himself a healer. Then the degree of Doctor of Medicine became accepted as a criterion for adequate medical knowledge. Toward the end of the colonial period medical societies were organized in many states and became the agencies controlling medical practice conferring licenses, as Massachusetts did in 1781. Some states atempted regulation by appointing boards of medical examiners, notably New York and New Jersey. By the middle of the 19th century conditions of medical practice and medical education had become so chaotic that state boards of medical examiners were permanently established. Led by Texas in 1873 nearly all states instituted this means of control by the end of the century.

The regulation of physicians by law has been continuous throughout the history of civilized peoples. It grew out of the practical realization that the health of individuals vitally concerned the very existence of the state, and therefore must be of prime concern to the state. The physician, being the only agency devoted to the study, treatment and prevention of disease, has been the chief subject for consideration by the state in its efforts to protect its own health. Individual citizens do not have the means to assess accurately the scientific attainments of one who claims to be a physician nor of his moral fitness. Since the state does have means of establishing the facts, it has assumed that duty. In reality, the scientific qualifications of a physician are determined in law by specifying minimums of training, and by examination. No equivalent means have been formed for judging moral qualifications. This area has been left to physicians themselves. Although good moral character is required by law society can only assure it indirectly by recourse to civil suit in suspected cases of immoral practice. The first known significant response was the ethical precepts of the Greek physicians represented by the Hippocratic Collection. The guilds and colleges of the middle ages were empowered by their charters to deal with quackery and immoral or unskillful practices. MacKinney shows from recent historical researches that Hippocratic ideals can be traced in an unbroken line through the Dark Ages and into the 15th century. An example is from a 10th century manuscript now in Chartres and titled:

WHAT SORT OF PERSON A PHYSICIAN SHOULD BE

"Let us now explain what sort of person a physician should be. He should be gentle in manners and modest, with the proper amount of reliability. He should be neither lacking in knowledge, nor proud; he should take care of rich and poor, slave and free equally for among all such people medicines are needed. Moreover, if certain compensation is offered, let him accept rather than refuse. If, however, it is not offered, do not demand it because, however much each one pays, the compensation for medical services cannot be equated with the benefits. Moreover, enter the homes you visit in such a manner as to have eyes only for the healing of the sick. Be mindful of the Hippocratic Oath, and abstain from all guilt and especially from immorality and acts of seduction. Keep secret everything that goes on or is spoken in the home. Thus the physician himself, and the art, will acquire greater praise. The physician should have slender, fine fingers so as to be agreeable to all and to be subtle to his touch. Hippocrates himself said this. The physician should be no less agreeable in conversation, and not wanting in philosophy. He should be unassuming in manners so that both perfection in the art and good manners may be harmonized insofar as is possible."

This is the fifth installment of a paper presented before the Detroit Academy of Medicine at the Dearborn Inn, November 12, 1957.

SPECIAL COUNCILOR MEETINGS SOLVE PR COMMUNICATIONS PROBLEM

Two months ago when the Michigan State Medical Society was planning the participation phase of its new Seal of Assurance Plan, the Society faced a monumental communications problem. It was plain that reliance on just a mail campaign would not be enough. The story of the new plan would have to be explained to every MSMS member by someone who knew the complete evolution of the plan, from the survey last summer, to the House of Delegates meeting last fall, to the eight months' work by the Medical Care Insurance Committee since then.

Consequently, from May 7 to May 21, the sixteen lower peninsula Councilors held special briefing district meetings to which they invited their county medical society officers, delegates and alternate delegates. They, in turn, asked the MSMS and MMS "panels" questions about every phase of the new program; and it is a credit to the subsequent efforts of these key men when they returned home that many county societies (Van Buren first!) reached their 100 per cent participation figure in the early stages of the "sign-up" campaign. The two upper peninsula Councilors achieved like results with personal letters to each MSMS member in their respective districts.

This speedy response of the medical profession to support its own plan is but another example of the importance of good communications to good public relations.

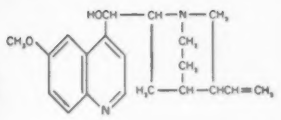
Progress in SYNTHETIC CHEMISTRY
EQUALS
Progress in CHEMOTHERAPEUTICS

"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

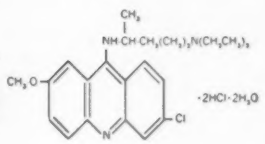
"... Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

"... the least toxic of its class ..."[3]

QUININE



ATABRINE® DIHYDROCHLORIDE



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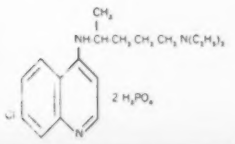
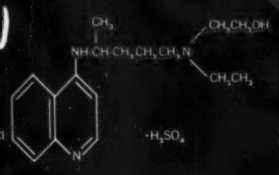
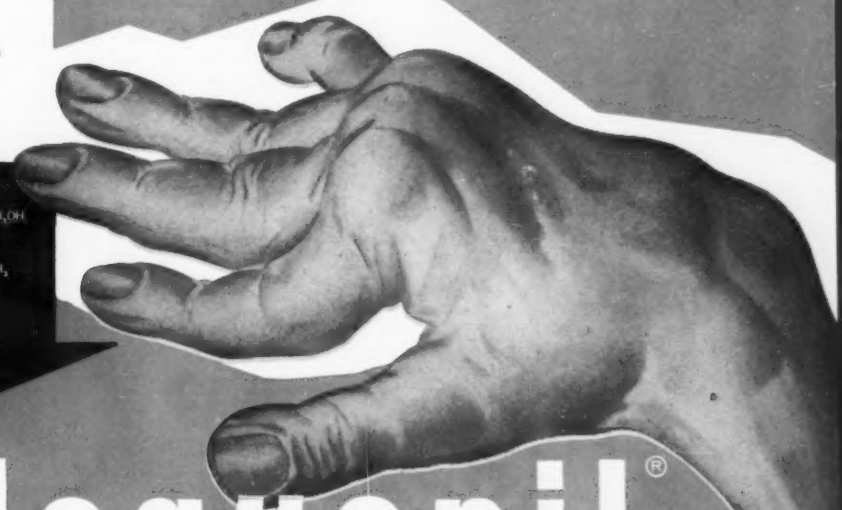


Now





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Remarkably effective in RHEUMATOID ARTHRITIS

SIDE EFFECTS MARKEDLY REDUCED

DOSE: **Initial** – 400 to 600 mg. (2 or 3 tablets) Plaquenil sulfate daily.
Maintenance – 200 to 400 mg. (1 or 2 tablets) daily.

SUPPLIED: Tablets of 200 mg., bottles of 100.

Write for Booklet

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REFERENCES:
1. Sherbel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
2. Schoch, A.G., and Alexander, L.J.: The Schoch section, *Bull. A. Mil. Dermatologists* 5:25, Nov., 1956.
3. Krahlet, Theodore: Arch. Dermat. 73:572, June, 1956.

Editorial Comment

PREMATURE APPLAUSE

Press association teleprinters chattered last week with seemingly momentous news from Boston: "Discovery of a mold extract which seeks and destroys fresh blood clots in minutes . . . can be used safely on the sickest patient . . . credited with furnishing quick relief for sufferers of heart attacks." Editors front-paged the claims, which had been announced by the Massachusetts Heart Association.

No one was more dismayed by the sensational stories than Dr. Mario Stefanini of Boston's St. Elizabeth's Hospital, who had worked for two years to get the extract (an enzyme) from common molds. He has found that it dissolves the fibrous part of clots in animals and has tested its safety in 25 humans. But it will be two years, he estimates, before its value in relieving the symptoms of heart attacks and strokes can be shown. In any case it cannot reverse the original damage done by the clot. There is no assurance that the extract can be produced commercially.

By no coincidence, the heart association was having a fund drive when it announced Dr. Stefanini's work.—*Time*, March 3, 1958.

A HOUSE DIVIDED

"In the past twenty-five years there have been startling sociologic changes in these United States —many of them having a profound influence upon medicine. And surely more changes are in prospect. It is important to medicine, as it is to any segment of the nation's population, that those changes be for the good of the whole nation.

So, it is disquieting, to say the least, that medicine is a house divided. The segments are easy to see. There is a small segment made up of the "informed" physicians—those who have studied the current social, economic, and medical problems and their interrelationships. That small segment contains the leaders of "organized" medicine—a group of men who have dedicated no small part of their lives and fortunes to a program that will insure that the wheel will turn in the direction of growth, not decadence.

The larger segment of the divided house is made up of men who are uninformed or partly informed. Herein lies medicine's weakness.

Although there may be various reasons that a large number of physicians are uninformed, it seems probable that the major factor is a lack of interest on their part. That thought is based upon the simple truth that people learn quickly and completely about things in which they have a keen interest.

There is evident danger in this situation. If changes are to take place in the medical-social scheme, physicians are the people most able to turn those changes to the advantage of the nation. They are the potential guides for this part of the nation's destiny. But a guide who is uninformed or uninterested is no guide at all.

The remedy for all this is obvious—obvious but not simple. Some means must be found to insure that more physicians become informed. Finding those means is a complicated business. In this modern world, there are more and more things to compete for the physician's interest. What can be done to make paramount his interest in everything that relates to the medical-social setting? The answer to that question is the greatest single challenge to medicine's leaders."—GP published by the American Academy of General Practice, March, 1958.

STUDY OF INSURANCE PLANS PROPOSED

In a message to the Legislature dated February 25, 1958, Governor Harriman proposed and requested approval for a study of the Blue Cross and Blue Shield plans operating in the State. It is pointed out that the laws governing these rapidly growing plans are in need of modernization. Says the Governor, in part:

In a recent decision disapproving an application by the Associated Hospital Service (Blue Cross) of New York, for an increase in subscriber rates, approximating 40 per cent, the Superintendent of Insurance indicated that, in several significant respects, the operations of these plans were beyond his purview. He also indicated the need for a change in the statutory requirements relative to the maintenance of a contingent surplus fund. Legislation has been introduced to permit a reduction in these funds. The moneys so released can be used to pay claims and expenses. This proposed change will permit a greater degree of flexibility, while at the same time recognizing the needs of the plans to be able to meet unexpected contingencies. It will also permit requests for changes in subscriber rates to be determined by the Superintendent of Insurance on a more realistic basis.

It would seem to be only common sense and certainly in the public interest to review the plans from time to time in the light of the rapid social and other changes that are taking place in our economy, especially as there has been no "Thorough review of their operations, conducted by an impartial body" since the 1930's.

The entire message was reproduced on page 1594 of the May 1 issue for the information of our membership. We feel that few will disagree with the intent of the study and that most will concur in the proposed plan to implement it. We urge all to read it carefully.—*New York State Journal of Medicine*, June 1, 1958.

MY DAD— HE HURT HIS BACK REAL BAD

"It happened at work while he was putting oil in something"

"He told Mom his shoulder felt like it was on fire"

"He couldn't swing a bat without hurting"

"But Doctor gave him some nice pills--and the pain went away fast"

"Dad said we'd play ball again tomorrow when he comes home"

AND THE PAIN WENT AWAY FAST

FOR PAIN

Percodan®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) **TABLETS**

ACTS FASTER...
usually within 5-15 minutes

LASTS LONGER...
usually for 6 hours or more

MORE THOROUGH RELIEF...
permits uninterrupted sleep through the night

RARELY CONSTIPATES...
excellent for chronic or bedridden patients

and now... **NEW**

Percodan®-Demi

VERSATILE

New "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Available through all pharmacies.

Each PERCODAN® Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Literature? Write

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Richmond Hill 18, New York

*U.S. Pat. 2,628,185

premenstrual

'DIURIL'

(CHLOROTHIAZIDE)

FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

". . . in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

DOSAGE: one 500 mg. tablet 'DIURIL' daily—beginning the first morning of symptoms and continuing until after onset of menses. For optimal therapy, dosage schedule should be adjusted to meet the needs of the individual patient.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

DIURIL is a trade-mark of Merck & Co., Inc.

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AMA Washington Letter

THE MONTH IN WASHINGTON

The Hill-Burton program for U.S. grants to states to help build hospitals and other health facilities has run a successful course for almost twelve years. It has never been cut back in scope, and once (in 1954) it was expanded to take in diagnostic-treatment centers, nursing homes, chronic disease hospitals and rehabilitation centers.

On the overall, the U.S. puts up one-third of the money for a state's projects, but the state may give individual projects as much as two-thirds of their costs.

In the twelve years, 3,725 projects have been completed, are under construction or have been approved. They represent a total investment of about $3 billion, just under one-third of it federal money. Included are 156,658 hospital beds, 4,542 nursing beds, and almost 1,000 other facilities, such as rehabilitation centers.

Congress, as it has several times in the past, now is being asked to renew the program, which no doubt it will do. Also, the Department of Health, Education, and Welfare and several organizations in the health fields have looked over the twelve years' experience, and want some changes made in the way the program is handled. None of them, however, wants to end it.

The American Medical Association, for example, is suggesting that diagnostic-treatment and public health centers be dropped from the program, and that the mandatory emphasis on rural communities also be eliminated. These and other AMA recommendations are the result of a fourteen-state survey by the association.

Also, the AMA joins with the Department of Health, Education, and Welfare in proposing that emphasis be placed on facilities for the chronically ill and nursing homes, and that states be given more freedom in shifting money among the various categories.

Both the AMA and the AHA want Congress to authorize loans for hospitals and nursing homes, with the AMA recommending that loan guarantees be offered to proprietary as well as nonprofit institutions.

Before Congress are a dozen or more other suggested changes. Several groups want the research fund raised from the present $1.5 million a year to $4 or $5 million, and HEW would like to be able to advance money for planning when this action would hurry construction. HEW also, along with several Congressmen and state medical societies, would like to see the eligibility requirements eased so more nonprofit groups can build diagnostic-treatment centers. Another HEW proposal would recognize a rehabilitation center even if it did not furnish psychological, social and vocational evaluation services, as well as medical; now the center has to furnish all four services.

At this writing, indications are Congress will not allow a slip-up in extending the program, which is scheduled to expire June 30, 1959, even if it has to move along a simple extension bill, then try to work out agreement on all the suggested changes.

Regardless of what happens, Hill-Burton is undergoing more friendly—but critical—examination than it has experienced since its birth in 1946.

Notes.—American Association of Medical Colleges estimates that the country's 85 medical schools will require $275 million for rehabilitation and new construction in the next few years, not including money for research and hospital construction.

To learn how far our supplies could be stretched in event of nuclear attack, the Office of Defense Mobilization has asked Public Health Service to survey 700 wholesale drug houses, surgical supply firms and chain drug store warehouses for an inventory of their stocks.

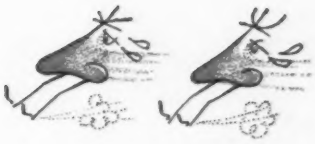
American Medical Association, among other groups, is supporting legislation that would request President Eisenhower to call a 1960 White House Conference on the problems of the aged. However, HEW sees no need for the conference, nor does it favor suggestions that a new bureau be set up to handle the problem, nor a commission created.

After conclusion of hearings, a House subcommittee has under consideration legislation for "bricks-and-mortar" U.S. grants to help medical and dental schools finance buildings and purchase of equipment; money could not be used for general operating expenses.

Dr. Thomas H. Alphin has resigned as director of AMA's Washington Office to become associate medical director of the Equitable Life Assurance Society at the group's main office in New York. Dr. William J. Kennard, deputy director, has been named acting director of the Washington Office.

VA is calling for bids on 12 construction projects estimated to cost a total of at least $4.2 million. Locations include Murfreesboro, Tenn.; Tomah, Wis.; Columbia, S. C.; Bay Pines, Fla.; Newington, Conn.; Iowa City, Iowa; West Roxbury, Mass.; Rutland Heights, Mass.; Walla Walla, Wash.; Wood, Wis.; Wadsworth, Kan.

running noses . . .



and other hay fever symptoms

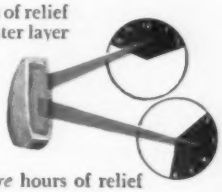
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action – systemically – with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes–lasts for hours. Running noses stop, congested noses open–and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first–3 to 4 hours of relief from the outer layer



then–3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

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TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

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AMA News Notes

GUNNAR GUNDERSEN—112TH PRESIDENT

In taking the oath of office as the 112th president of the American Medical Association, June 24, in San Francisco, Dr. Gunnar Gundersen called attention to the physician's obligations on the international scene. The sixty-one-year-old La Crosse, Wisconsin, surgeon said: "As both physicians and citizens, we must see that medicine plays its full role, not only in promoting better world health, but also in helping the search for brotherhood and peace."

As American citizens, Dr. Gundersen said, "our first duty is to this country. But as members of the brotherhood of man, we also have a duty toward all men who yearn for freedom, dignity and peace." He further pointed out that "medicine can play a vitally effective part in bringing reality to the dream of world peace. For medicine, despite the designs of politicians or dictators, is above the harsh conflicts of ideologies and power policies. Medicine, like religion, speaks a universal language which passes all barriers of race, creed, color and nationality."

Dr. Gundersen has been active in state and national medical affairs throughout his practice. He was president of the State Medical Society of Wisconsin in 1941-42, served on a number of the society's committees, and was speaker of its House of Delegates for about five years. He was a member of the AMA's House of Delegates in 1937-38 and was elected to the AMA Board of Trustees in 1948. He became chairman of the Board in June, 1955. His keen interest in hospital affairs and the quality of hospital service led to his election as the first chairman of the Joint Commission on Accreditation of Hospitals when it was formed in 1951. He served in that capacity until 1953.

He now operates the Gundersen Clinic in La Crosse, along with three of his physician brothers, Sigurd B., Alf H., and Thorolf E. Two other physician brothers, Drs. Trygve and Sven M. Gundersen, are practicing in Boston and Hanover, New Hampshire, respectively. The Gundersen Clinic, which handles 3,000 to 4,000 new patients a year, was established in 1927. It attracts people from all over the United States and is operated in conjunction with the La Crosse Lutheran Hospital next door.

Dr. Gundersen did his preparatory school work in Oslo, Norway, and returned to the United States to obtain his B.S. degree from the University of Wisconsin in 1917, and his M.D. from Columbia University in 1920. He served his internship and residency at La Crosse Lutheran Hospital from 1920 to 1922. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons and the International College of Surgeons, a member of the Council of the World Medical Association, and a member of the American Public Health Association.

NEW CAREER FILM

A little seven-year-old youngster is helping influence students to choose a career on the health team. She's Julie Morgan, the star of a new 16mm medical health career recruitment film produced by the American Medical Association, the American Hospital Association and E. R. Squibb and Sons. "Helping Hands for Julie" tells the dramatic story of the fight to save Julie's life. The helping hands aiding the doctors in finding the correct diagnosis of meningitis are those of the nurses, medical technologists, x-ray technicians and medical record librarians. With the diagnosis made, the drugs of the pharmacist, the nourishing food of the dietitian, the restorative work of the physical therapist, and the care of the nurses bring Julie back to health.

Medical societies and auxiliaries may arrange for bookings of this 30-minute, black and white sound film through AMA's Film Library after July 1.

HIGH SCHOOL SCIENTISTS EXHIBIT IN SAN FRANCISCO

The American Medical Association was host to two teen-age scientists during its Annual Meeting in San Francisco. As a result of their winning the AMA's top citations at the National Science Fair in Flint, Michigan, May 7-10, Clare L. Chatland, sixteen, Missoula, Montana, and David R. Brown, fifteen, Minneapolis, Minnesota, showed their exhibits to 30,000 physicians and guests at the San Francisco meeting.

David's exhibit on humeral transplants illustrates the method by which fetal mouse bones become ossified when transplanted into hostile media, and Clare's work is an experiment with mice showing how hypersensitizing agents enhance antigen-antibody reactions.

Their exhibits were chosen by a special AMA committee, headed by Dr. Alphonse McMahon, chairman of the AMA Council on Scientific Assembly, in a field of 281 entries from forty-one states, the District of Columbia, Alaska, Hawaii, Germany and Japan.

In addition to the two top AMA awards, honorable mention citations were presented to Robert L. Sayre, seventeen, Huntington, West Virginia, for his exhibit on "The Neurohumeral Theory and Cardiac Inhibition," and to Barbara Ann Conway, sixteen, Chatanooga, Tennessee, for her study of "Experimental Teratology," showing the development of congenital malformations when pregnant rats are subjected to stress.

Hundreds of county and state medical societies are now co-operating with and supporting their local science fairs, which send winners to the National competitions. The 1959 Fair, sponsored by Science Clubs of America, 1719 N Street N.W., Washington, D. C., as an encouragement to the study of science, will be held May 6 to 9 in Hartford, Connecticut, and in 1960 in Indianapolis, Indiana.

X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.

Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* — full-strength — 100 mg. (light blue).

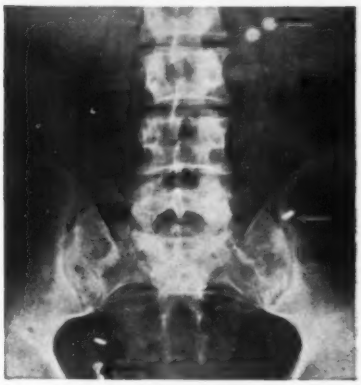
NOW AVAILABLE: Pyribenzamine *Lontabs* — half-strength — 50 mg. (light green) — for children over 5 and for adults who require less antiallergic medication.

PYRIBENZAMINE® hydrochloride (tripelennamine hydrochloride CIBA)
LONTABS® (long-acting tablets CIBA)

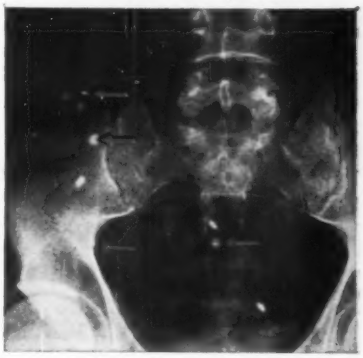
9/2562MA

CIBA SUMMIT, N. J.

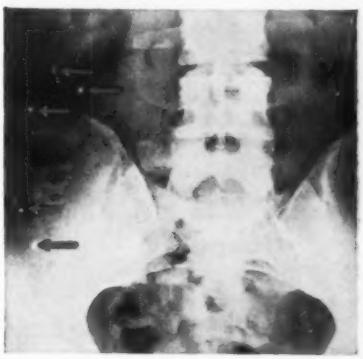
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.

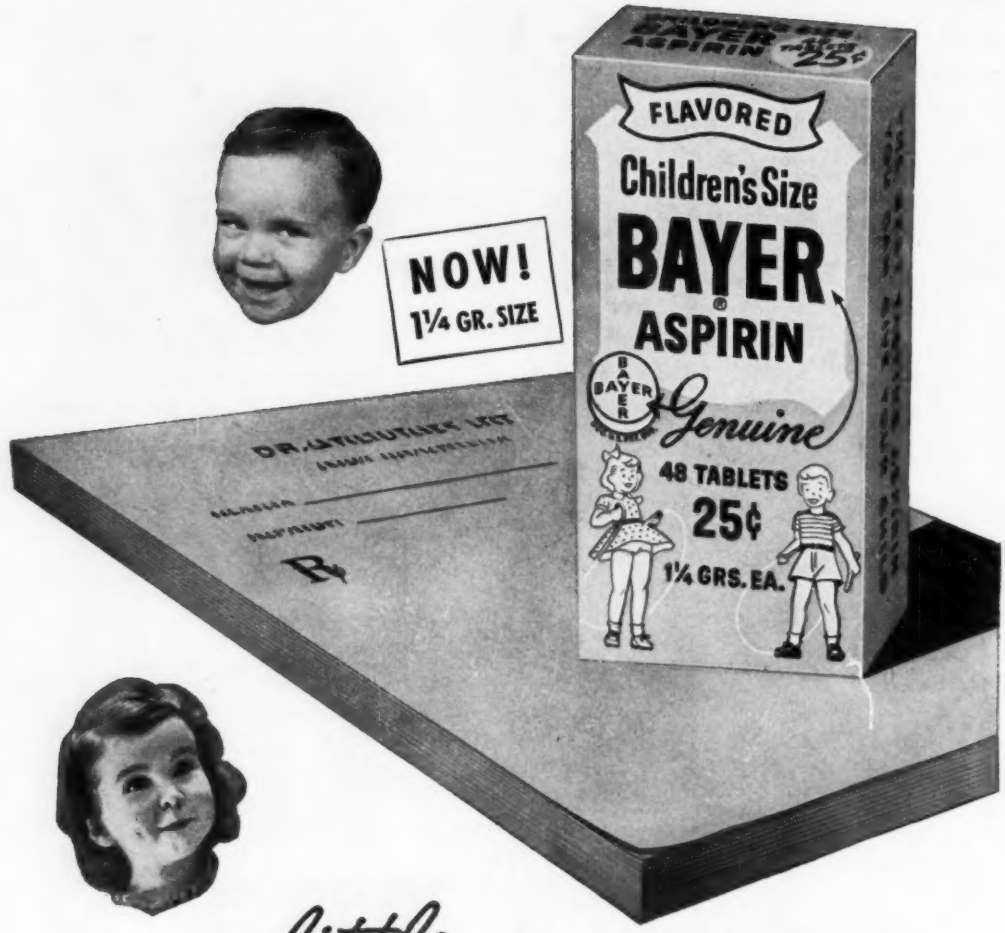


4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.





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The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

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Low Dosage KYNEX* for G.U. Infections

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references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
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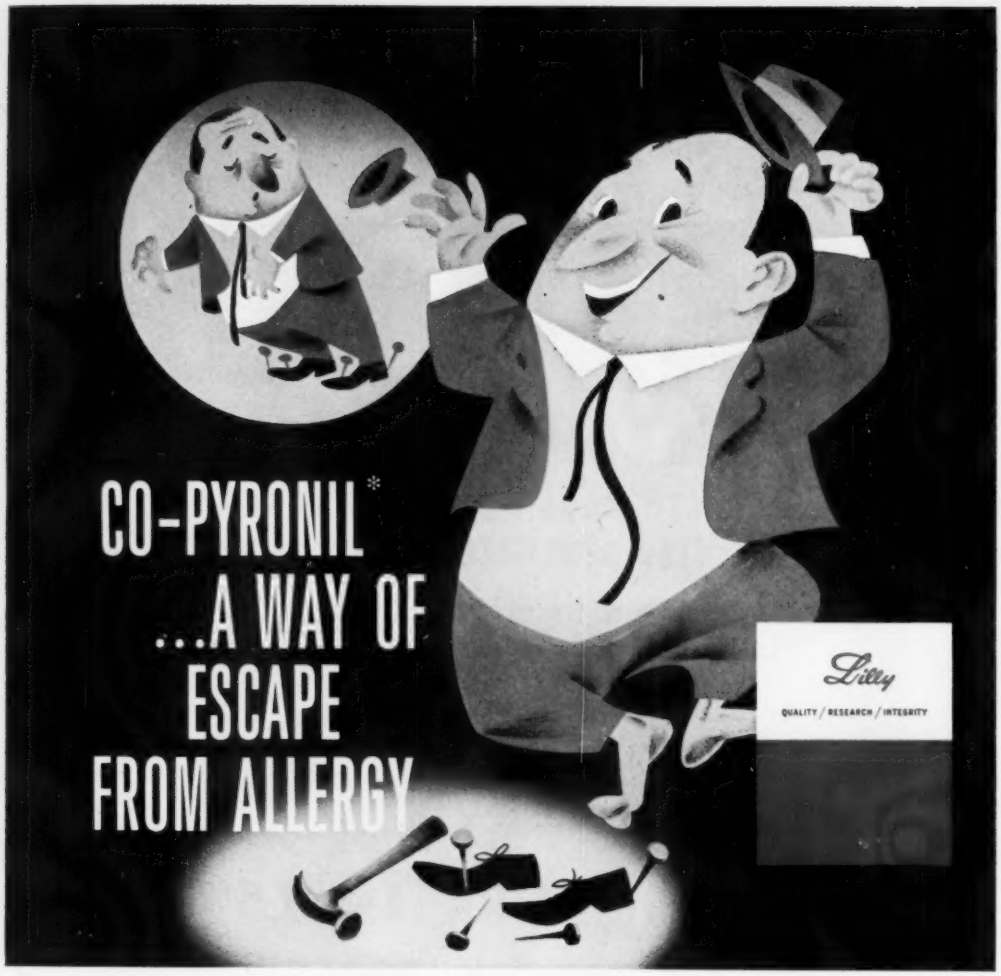

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VOLUME 57 JULY, 1958 NUMBER 7

The Management of Coronary Diseases and Anginal Seizures

By Leon H. Goldberg, M.D.
Nyack, New York

THIS IS a maiden presentation, introducing the plant Chelidonium majus (commonly known as the swallowwort) as a new and effective remedy in the management of coronary artery disease and angina pectoris. Prepared by a special process, the extract of the total alkaloids of the plant, biologically standardized, is available under the pharmaceutical name of Kelid.

Chelidonium majus is a member of the Papaveraceae family of plants. Its individual alkaloids, chelidonine, alpha and beta homocheliconime, and cherylrythrin, are reputed to be smooth muscle relaxants. In searching for a remedy for hypertension, I assumed that the total alkaloidal extract would act much as its individual alkaloidal components. After several years of clinical trial, it became apparent that the drug had no effect upon the blood pressure. But what emerged pointedly was the fact that a good number of hypertensile patients, who had coronary artery disease and angina pectoris, were relieved of their painful seizures over extended periods of time. Accordingly, in April, 1954, an organized study of the effect of the drug on the anginal sufferer, in general, was instituted. After another three years of clinical observation, it became strikingly evident that the total alkaloidal extract of the plant brought gratifying and prolonged relief to the anginal sufferer.

In investigating the action of the total alkaloids of the plant, a pharmacologic paradox presented itself. In the light of the clinical experience of over a ten-year period, the total alkaloids were investigated for their effect upon the heart and the coronary circulation.

Pharmacologically, the total alkaloid fraction acts differently from any of its individual alkaloids. The rhythmic contraction of isolated smooth muscle is generally increased in amplitude. The effect on smooth muscle stimulants, such as histamine, is not antagonized. The isolated perfused rabbit heart is increased in the amplitude of the beat and slightly slowed in rate. Tracings are indistinguishable from those produced by khellin using the same procedures. The drug is "washed out" of muscle only with difficulty.

Perfusion experiments indicate an increased flow through the coronary circulation. Electrocardiograms in the intact dog show little change except a slight slowing of the rate. The effect was not altered after vagal inhibition by atropine. The blood pressure was not significantly affected by small intravenous doses although a transient increase followed by a slight depression was observed. This latter effect has not been seen clinically.

The drug does not appear to be very toxic. Intravenous injections of as much as 2 cc./Kg. do not produce apparent toxic effects in the an-

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Presented before the Michigan Academy of General Practice, Detroit, November 6, 1957.

Dr. Goldberg is a Fellow of the American College of Cardiology, Associate Member of the American College of Physicians, and a Diplomate of the American Board of Internal Medicine.

TABLE I. CORONARY ARTERY DISEASE—ANGINA PECTORIS
42 Cases

Post Infarctional	Abnormal Resting E.K.G.	Normal Resting E.K.G.	H.T.C.V.D. Abnormal Resting E.K.G.	H.T.C.V.D. Normal Resting E.K.G.	Total
Male	Male	Male	Male	Male	
S.S. 47 P	F.B. 44	R.G. 51	H.F. 67 D	K.C. 63 D	
G.W. 53 P	H.B. 51	G.M. 54			
E.N. 59	A.G. 51	J.W. 54 P			
F.P. 61	J.O. 57 P	I.S. 61			
D.G. 67 P	L.W. 60 P	E.F. 62 P			
R.K. 67	H.G. 62 P	A.S. 65			
	E.H. 67	J.P. 68 P/D			P—Pathol.
	H.S. 70 P	T.M. 70 P			
	H.H. 76 P				D—Deaths
	F.S. 89 D				
Female	Female	Female	Female	Female	
L.B. 51 P	M.C. 59	L.C. 79 D	A.F. 59 D		
H.T. 52	D.M. 60		B.V. 70		
N.S. 59	G.B. 61 P				
H.S. 66 P/D	E.B. 63 P				
B.S. 70	S.B. 69 P				
	A.C. 70 P				
	E.B. 72				
	K.E. 77 P				
Male 6	Male 10	Male 8	Male 1	Male 1	Males 26
Female 5	Female 8	Female 1	Female 2	Female 0	Females 16
Deaths 1	Deaths 1	Deaths 2	Deaths 2	Deaths 1	Deaths 7

TABLE II.

SUMMARY OF ANGINA PECTORIS PATIENTS TREATED

Differential Diagnosis	Male	Female	Total	Deaths
Postinfarctional angina	6	5	11	1
Coronary artery disease with abnormal resting E.K.G.	10	8	18	1
Coronary artery disease with normal resting E.K.G.	8	1	9	2
Hypertensive cardiovascular with abnormal resting E.K.G.	1	2	3	2
Hypertensive cardiovascular with normal resting E.K.G.	1	0	1	1
Total	26	16	42	7

TABLE III. AGE DISTRIBUTION IN DECADES

Male			Female		
Age	No.	Deaths	Age	No.	Deaths
40-50	2	0	40-50	0	0
50-60	8	0	50-60	5	1
60-70	12	3	60-70	5	1
70-80	3	0	70-80	6	1
80-90	1	1	80-90	0	0
Total	26	4	Total	16	3

esthetized dog. Thus a pharmacologic basis for the clinical results obtained appears to be established.

Materials and Methods

The patients for this evaluation were obtained from an unselected group of ambulatory clients, as seen in private practice in a suburban area adjacent to New York City. Only those patients were included whose history and other findings permitted an unequivocal diagnosis of angina pectoris.

There are forty-two cases in all. All had angina pectoris of varying intensities and varying frequencies. No attempt was made to qualify the intensity of the pain. For the sake of simplicity, let us say that they all suffered moderately severe seizures. Each sufferer is unto himself a case. Each patient is unto himself a series. And when two patients with the same noses will come to me, then I will know that they suffer their anginal seizures with equal intensity.

They were divided into five clinical groups:

(1) Six men between the ages of forty-seven and sitxy-seven; and five women between the ages of fifty-one and seventy make up the postinfarctional group.

(2) Ten men between the ages of forty-four and eighty-nine and eight women between the ages of fifty-nine and seventy-seven constitute the group of anginal sufferers inscribing abnormal resting electrocardiograms.

(3) Eight men ranging in age from fifty-one to seventy; and one woman of seventy, all of whom presented unequivocal clinical evidences of coronary artery disease and angina pectoris, showed normal resting electrocardiograms.

(4) One man, aged seventy-six, and two women, ages fifty-nine and seventy, are in the hypertensile cardiovascular group with abnormal resting electrocardiograms.

(5) One man, aged sixty-three, an hypertensile for over twenty-five years, inscribed a normal electrocardiogram.

TABLE IV.

CORONARY ARTERY DISEASE—ANGINA PECTORIS—WITH CONCURRENT OTHER PATHOLOGIC CONDITIONS

					Deaths
Postinfarctional			Male		
	S.S.	47	Hiatus hernia –	1	
	G.W.	53	Duodenal ulcer	1	
	D.G.	67	Cardiomegaly + + + + –	1	
5			Female		
	L.B.	51	Anxiety neuroses + + + +	1	
	H.S.	65	Gall-bladder disease with stones		
Abnormal resting E.K.G.			Male		
	J.O.	57	Chronic rheumatic valvular heart disease		
	L.W.	60	Hypertrophic gastritis	1	1
	H.G.	62	Primary pulmonary emphysema –		
	H.S.	70	Primary pulmonary emphysema –		
	H.H.	76	Hypertrophied prostatitic—Uric acid renal calculi	1	
10			Female		
	G.B.	61	Gall-bladder disease with gallstones	2	1
	E.B.	63	Chronic rheumatic valvular heart disease		
	A.G.	70	Chronic rheumatic valvular heart disease		
	S.B.	69	Primary pulmonary emphysema	4	
	K.E.	77	Primary pulmonary emphysema		
Normal resting E.K.G.			Male		
	J.W.	54	Gastric diverticulum	1	
	E.T.	62	Symptomatic ankylosed cervical spondylitis	1	
4	J.P.	68	Chronic rheumatic valvular heart disease	4	
	T.M.	70	Parkinson's disease	1	
			Total 19 (45% of all cases)	19	2
Deaths	J.P.	M. 68	Chronic rheumatic valvular heart disease. Normal E.K.G.—Infarction		
	H.S.	F. 67	Gall-bladder disease—Stones—Abnormal E.K.G.—Infarction		

There are seven deaths listed. Mrs. H. S., from the postinfarctional group, who had gall-bladder disease with stones, died on September 19, 1957. The pathologist reported marked and severe sclerosis with occlusion of right and left coronary arteries; old and recent infarcts of the left ventricle, of the apex, and of the posterior wall of the right ventricle, and mural thrombi of both right and left ventricles, and an embolus to the main branch of the pulmonary artery from thrombi in the right ventricle.

From the group inscribing abnormal electrocardiograms, the eighty-nine-year-old gentleman died in his easy chair.

From the group with normal electrocardiograms, J. P., sixty-eight, with chronic valvular heart disease, died of a myocardial infarction. Mrs. L. C., who enjoyed ten years of a cardiac symptom-free status, died at seventy-nine of a cerebrovascular accident.

Out of the four hypertensile patients, three are dead. H. F., sixty-seven, died of a cerebrovascular accident; Mrs. A. F., fifty-six, of an acute coronary occlusion and myocardial infarction, and J. C., sixty-three, of an acute coronary occlusion and myocardial infarction.

Five of the deaths were due to coronary artery disease, two to cerebrovascular accidents.

Because it is not uncommon to be confronted in our respective practices by an anginal sufferer with another concurrent disease, nineteen such instances are tabulated in Table V. They were labeled "P" in Table I.

TABLE V. CONCURRENT PATHOLOGIC CONDITIONS

Disease	No.	Deaths
Chronic rheumatic valvular heart disease	4	1
Primary pulmonary emphysema	4	
Gallbladder disease with stones	2	1
Anxiety neuroses (post-psychotic)	1	
Idiopathic cardiomegaly	1	
Hiatus hernia	1	
Hypertrophic gastritis	1	
Hypertrophic prostatitis with renal calculi	1	
Gastric diverticulum	1	
Duodenal ulcer	1	
Parkinson's disease	1	
Symptomatic ankylosing cervical spondylitis	1	
Total	19	2

I wish it were possible to present each of the forty-two cases in this study. Despite the fact that they are divided into groups, and that almost half of them have concurrent other pathologies, the presentation of the following cases will serve as a guide and yardstick to the management of the anginal sufferer, in general.

Case Reports

Case 1.—E. N., a fifty-eight-year-old normotensive man of average build and weight, suffered an acute coronary insult on October 8, 1954, while watching television. He was observed at home by his physician for four days and then hospitalized for two weeks when the painful seizure and shock recurred. Ten days after hospital discharge, another seizure occurred and he was again hospitalized for seven days. He was allowed to return to his work as a bookbinder on January 17, 1955,

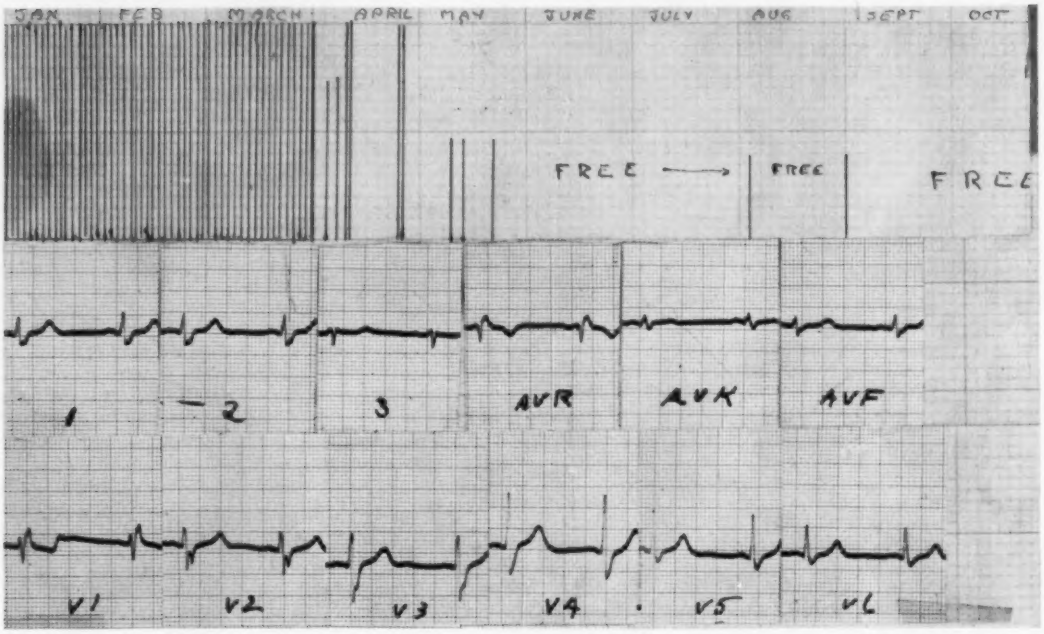

Fig. 1. Case 1. Mr. E. N., aged sixty-one. Graphic illustration of the course and remission of painful episodes. The vertical lines during January, February and March represent the frequency and the intensity of the anginal seizures. The electrocardiogram is the stabilized pattern he inscribed throughout.

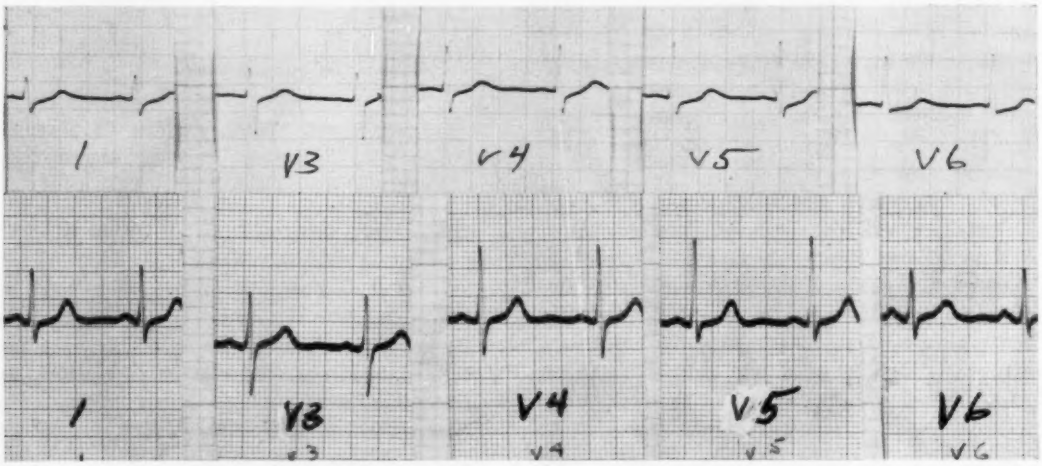

Fig. 2. Case 2. Mrs. G. B., aged sixty-one. Upper cardiogram, April 2, 1957; lower, September 3, 1957.

but he suffered daily painful episodes requiring nitroglycerin and occasionally Demerol for relief. On March 17, a severe painful seizure was relieved by Demerol only after one and one-half hours.

This patient was first referred to us by his physician from a neighboring state on March 22, 1955. He was depressed, anxious, tense and complained of dizziness and chest pain. Classical treatment between March 22 and April 4, was without beneficial effect and he suffered three episodes of severe pain in that period.

Kelid was begun April 4, 1955, 0.25 cc., three times a day. Despite increased mental tension due to economic circumstances, improvement was satisfactory. He reported very slight pains on April 6, evanescent pains on April 8, and marked improvement on April 10. The patient mowed his lawn on May 21, experiencing slight discomfort but no pain. He was symptom-free on June 11, 1955, and walked four to five blocks comfortably by November. Kelid was discontinued on August 18, 1956.

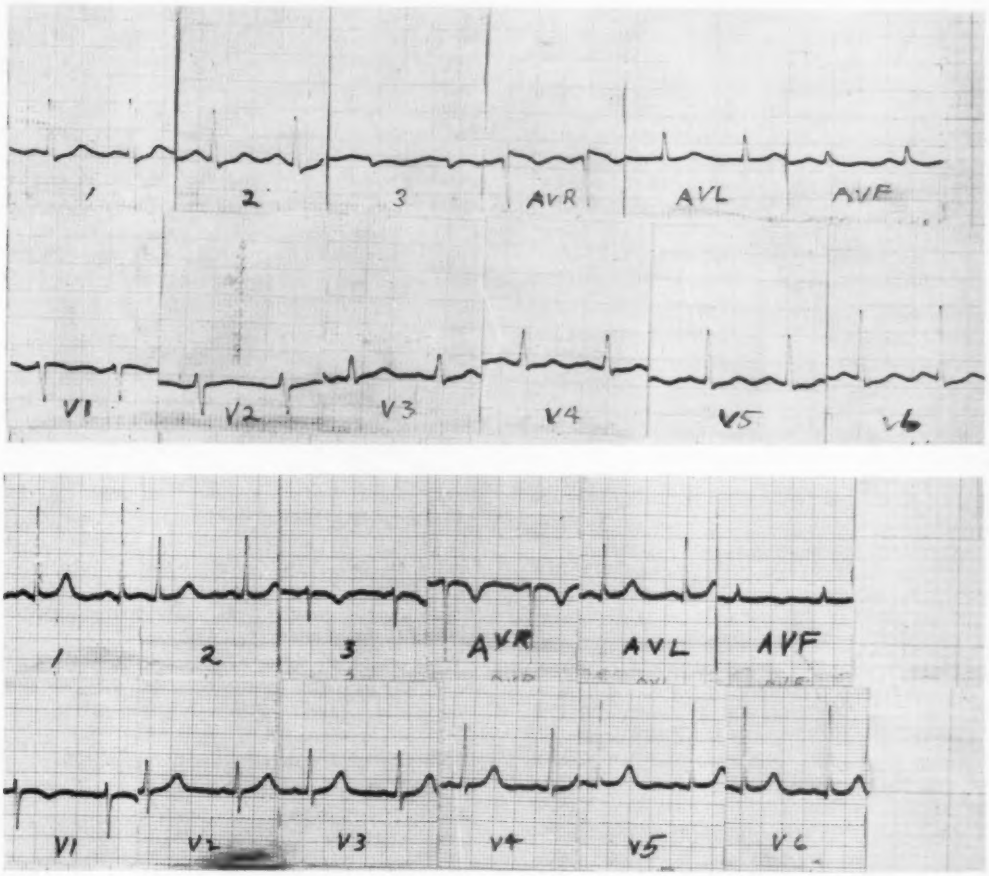

Fig. 3. Case 3. Mrs. E. B., aged sixty-three. Upper cardiogram, January 11, 1957; lower, May 3, 1957.

The patient's last visit to me was June 28, 1957. He has remained cardiologically symptom-free despite intercurrent coughs and colds, commuting to and from his daily work and walking seven blocks to and from the factory.

Case 2.—From the group inscribing abnormal electrocardiograms, is the case of G. B., a sixty-one-year-old woman. She was obese and evidenced a labile blood pressure ranging between 180/120 and 124/84 throughout the past twelve years. At no time could she endure a reduction regimen. She was hospitalized for her first anginal seizure in May, 1945. A normal electrocardiogram and a sluggish and poor functioning gall bladder without stones confused the young physician at that time.

She visited me in October, 1945, and presented a history clinically suggestive of angina pectoris. During 1946 and 1947, she suffered several acute episodes requiring Demerol. Following her husband's death in 1947, she presented a blood pressure of 120/84 and complained of chest pains radiating to the left shoulder and arm upon exertion. Kelid was prescribed at that time. The electrocardiogram showed normal reaction.

Much as she would stick to a diet for a week or so, she took her medication for similar short periods. Nonetheless, she enjoyed considerable relief. Following several recurring episodes of acute cholecystitis, she was reexamined radiologically in November, 1950. A Graham-negative gall bladder with a cluster of stones was found. The electrocardiogram showed no abnormalities.

In March, 1951, the stones were removed but her gall bladder was not removed. Following her surgery she remained clinically well until April, 1954, when her precordial distress recurred. Kelid was dispensed to her. Once more she discontinued her medication after several weeks. In August of 1954, she was awakened from her sleep by a dream in which she was being chased up hill and she suffered a deep, smothering substernal pressure and pain. She resumed taking Kelid, found herself free from pain and discontinued it herself once again. As the gall-bladder area showed clinical evidence of trouble, another x-ray study in December, 1954, demonstrated

once again a Graham-negative gall bladder but with a cluster of stones. The electrocardiogram gave normal findings.

She passed two uneventful clinical years until April 1, 1957, when she reported that she was having recurring episodes of throat fullness and spasms for several weeks. A resting electrocardiogram demonstrated depressed ST segments in leads 1, V_3, V_4, V_5 and V_6. Kelid was dispensed once again. She was then advised that her heart was under strain. She continued on Kelid until August 10, 1957, and remained symptom-free in that period. This time I discontinued the remedy.

She continued on her symptom-free status. Eighteen days later I reinstituted the Kelid therapy, not because of any symptoms, but as a prophylactic measure. On September 3, 1957, all the ST depressions returned to the isoelectric level. So impressed was she that she began and continues on as of this day, a dietary reduction regimen, on Kelid, remaining symptom-free.

Case 3.—Mrs. E. B., a normotensive female of average weight with mitral valvular disease and two-plus cardiomegaly, had two bouts of bronchopneumonia without failure between 1951 and 1952. Between 1952 and January 1957, she suffered from but mild colds and a few sore throats. On January 6, 1957, and again on January 7, 1957, she experienced daily seizures of precordial tightness of rather severe intensities. She was first seen on January 11, 1957. Kelid was dispensed. She inscribed an abnormal resting electrocardiogram that day. On January 18, she reported one evanescent mild episode during the week. She was left with a sense of ill feeling until February 11, when she reported a state of well-being. The medication was discontinued that day. In spite of a sore throat on March 24, 1957, she remained in a symptom-free state. On April 4, 1957, she reported a state of well-being. An electrocardiogram that day showed a return of all the ST depressions to their isoelectric lines. She remains symptom-free until this very moment.

Several other cases present graphic evidence of improvement in the electrocardiogram. We are not prepared to state that Kelid was responsible for the restoring the depressed ST segments to their isoelectric levels. Yet it is so nice to have graphic evidence of improvement concurrent with symptomatic relief, that I chose to present these two cases to you. I am satisfied that we consider it a happy clinical coincidence until further evidences are accumulated throughout the years. From our very practical point of view, the relief of the patient's pain and the concurrent anxieties are our principal aim. We do not treat the electrocardiogram.

Case 4.—This is selected from the group of patients with coronary artery disease who show no resting electrocardiographic abnormalities.

T. M., a seventy-year-old educator, had first suffered chest discomfort six years previously in 1949, at the time of unusual exertion. The pain returned in troublesome degree in the summer of 1955. His physician recorded a blood pressure reading of 150/90 in 1949 and had entered a diagnosis of coronary artery disease and angina pectoris with normal electrocardiogram in 1955. Nitroglycerin had been prescribed for use in the usual way.

The patient came under my care on November 28, 1955. Pulse was 68 and regular, blood pressure 150/80. The left hand evidenced a noticeable Parkinsonian tremor. His resting electrocardiogram showed no abnormalities.

Kelid was prescribed on that date, 0.25 cc. three times a day. The patient remained free of pain until December 26, 1955, when a severe four-hour attack was not relieved by nitroglycerin. Thereafter, the patient was symptom-free until unusual exertion caused a mild attack on February 15, 1956. Except for a brief painless "inner turbulence" on April 28, 1956, when temporarily out of medicine, the patient has continued to be symptom-free. He was last seen on September 30, 1957. He continued his activities as dean of a college and complained that when he walked uphill in humid weather, he experienced a few mild precordial twinges.

This gentleman has been taking Kelid since November, 1955, fully two years without any evidence of any side effects.

Miss K. E., the seventy-seven-year-old lady, with primary pulmonary emphysema and a moderately elevated hypertension of 160/100, has been on Kelid 0.25 cc. by mouth since June 18, 1946. She has been free from any precordial discomforts since August, 1946. She calls every three months or so from the city for a new supply of the drug. She has had no side effects. She has been on Kelid for eleven years.

On the other hand, about three out of the forty-two cases gave a history of nausea. In all three, half of the dose carried them along satisfactorily.

Case 5.—In 1940, J. C., a forty-nine-year-old man, presented himself with a history of hypertension over a period of fifteen years. He complained then of postprandial sub-xiphoid pain. He was seen infrequently during the next two years for minor intercurrent simple colds and upper respiratory infections. Blood pressure fluctuated, during this period, between 140/100 and 170/110. This patient was not seen during the war years, 1942-1947, but returned in May, 1947, with a diagnosis of coronary artery disease. Anxiety and distress were pronounced since he had awakened that morning with left precordial pain radiating to the left side of the neck, left arm and substernally. The incident was of short duration.

Simple expectant therapy was effective for a time

but during the following year, several infrequent bouts of mild to moderate angina were experienced. Blood pressure remained between 170/110 and 190/130 despite the concurrent use of several of the currently used anti-hypertensive drugs. The angina gradually became more severe and on September 8, 1948, Kelid was prescribed.

Improvement was gradual and satisfactory. The patient resumed his erstwhile church, social and business activities and remained cardiologically symptom-free. The electrocardiogram was normal as of December 11, 1948. On April 13, 1949, he reported the disappearance of an erstwhile nocturia.

In May of 1949, this patient reported fleeting red spots in the visual periphery; in 1952, he suffered several episodes of evanescent giddiness; in 1954, a brief episode of labyrinthitis. With these exceptions, he remained well, active and free from anginal attacks with unchanged blood pressure until April 22, 1955. On that date he drove his car to the side of the road, cut off the ignition and collapsed and died at the wheel at the age of sixty-four.

This patient had taken Kelid daily for seven consecutive years. He enjoyed seven years of an active and symptom-free life.

It is fully recognized that the clinical course of angina pectoris is highly variable and that this factor makes an evaluation of therapy extremely difficult. Our results, however, seem to us to be unequivocal. Weighed against the experience of the years, we have been more than gratified with the successful results we have obtained with this drug.

Results

The anginal syndrome was definitely improved in all of our forty-two patients. Improvement was usually noted within two weeks and the patients were able to resume reasonable patterns of physical activity within two months following the initiation of Kelid treatment. It was usually possible to discontinue medication after the sixty-day period and still maintain the patient on a cardiologic symptom-free status. Two years follow-up on most of the thirty-five patients who remain available to us, indicates freedom from anginal attack in the post-treatment period.

The side effects are minimal. Although half a unit appears to be adequate as a maintenance dose, I am of the opinion that such a dose is not too effective. On the other hand, in two instances in which one unit or 0.25 cc. seemed to be not quite as effective as our experiences dictated, the dose was increased to one unit and a half. This dose was tolerated well and satisfactory improvement followed.

In theory, there are several ways in which Kelid might relieve the anginal syndrome. A direct action on the smooth muscle of the coronary arteries could improve coronary flow. Or, since coronary flow occurs during diastole, greater myocardial relaxation duing the diastolic phase could provide improved myocardial nutrition. Or lastly, a lessening of the sensibility of the sensory afferent pain receptors in the myocardium could be involved.

A lessening of reflex sensitivity does not appear to be in accord with the pharmacologic or clinical observations.

The most attractive theory assumes that Kelid causes increased coronary flow during the period of diastole. The slight slowing of the beat both in the normal animal and on heart perfusion when considered with the increased coronary flow and the increase in amplitude of the beat provide grounds for this assumption. The fact that the drug does not "wash out" readily from muscle bath preparations accounts, perhaps, for the long-lasting effectiveness of the small doses employed and the therapeutic after effect.

Summary

The use of Kelid, a biologically standardized total alkaloid extract from a papaveraceous plant, Chelidonium majus, has given satisfactory, successful results in the management of patients with angina pectoris.

Improvement usually appears within two weeks and patients are usually symptom-free within two months at a reasonable pattern of physical activity.

Follow-up studies over a two-year period indicate that patients remain relatively free of anginal attacks after discontinuation of medication.

No toxicity was observed in the doses used and side effects, such as nausea, were rare and minimal.

The drug appears to act by increasing coronary flow during the diastolic phase of the cardiac cycle. It does not appear to be an "antispasmodic" and has no generalized effect on the blood pressure.

A dosage of 0.25 cc. orally or one soft gelatin Kelid capsule three times a day is recommended

(Continued on Page 986)

Surgical Lesions of the Lower Extremities in Diabetics

A Classification of Lesions Arrived at Clinically, Applicable as a Guide to Surgical Procedure

By Frederick W. Williams, M.D., F.A.C.P.,
and Thomas J. O'Kane, M.D., F.A.C.S.
Bronx, New York

LESIONS of the lower extremities associated with diabetes can be classified by purely clinical methods. This statement we are able to make as a result of our having devised a classification nineteen years ago and applying it through the years. In accordance with our modern and progressive advancements in the treatment of infection, our progressive knowledge of peripheral vascular disease and the developments of technique in surgery, we offered this classification originally to be used as a guide for operation level. In the light of our present knowledge, we would venture to say that this classification arrived at clinically, is definitely applicable and is not only a guide for operation or amputation level but also is now a guide for the conservative treatment, considering the wide variety of antibiotics that are now available. In the early days, all the lesions of the lower extremities were vaguely thrown into one large group and named "diabetic gangrene."

Classification

Doctors Root and McKittrick, in their early book on surgery in the diabetic patient, suggested that there were certain lesions that were vascular and certain lesions that had an infectious element. This was the first real contribution toward classifying and establishing lesions. In 1937[1] and 1938,[2] and again in 1940,[3] we published our classification. It was based upon the knowledge of peripheral vascular disease and applied to diabetic legs; it was also based upon the other fundamental pathological element, infection. We had arrived at the conclusion at that time that if we were going to classify the lesions of the lower extremities in diabetic patients on the basis of two fundamental pathological elements, there must of necessity be two fundamental classifications: purely vascular and purely infectious. With two elements there must be a third group of lesions. These were mixed lesions. In the mixed lesions, the only contribution that we had made was that they could be sub-classified into three types, dependent upon the degree of impairment of peripheral arterial circulation.

After clinical experience, we had arrived at three types of mixed lesions. The first was marked arterial impairment with infection; the second, moderate vascular arterial impairment with infection; and the third, slight vascular arterial impairment together with infection. Thus, we then found ourselves with the classification that gave us five types of lesions (Table I). The first type was a lesion which was purely vascular and characterized by marked arterial insufficiency on an arterioslerotic basis. The lesion itself, initially a gangrene, may vary in extent (Fig. 1-3), and there is no evidence of infection. The second type, the mixed lesion, we vernacularly call a 3-plus vascular mixed. This was characterized as a purely vascular lesion by marked arterial insufficiently, initially a gangrene, and having infection superimposed (Fig. 4). Once the infection was superimposed, this was an entirely different lesion from the purely vascular, with absence of infection. The third type was the 2-plus vascular mixed lesion, characterized by moderate arterial insufficiency (the initial lesion is an infection and then a gangrenous lesion is superimposed). This usually occurs because an edema and swelling compress the collateral circulation and thrombose the veins. A 2-plus vascular mixed lesion is illustrated in Figure 5. The 1-plus vascular mixed lesion is quite readily understood. It has slight arterial insufficiency, is initially an infectious lesion but the circulation (and the collateral) present, is adequate to prevent the superimposition of

Presented before the Michigan Clinical Institute, Detroit March, 1957.

TABLE I. LESIONS OF THE LOWER EXTREMITIES

Class	Criteria	Clinical Findings	Lesion	Procedure
Purely vascular	Marked arterial deficiency, no infection	Marked P.V.D.* Initial lesion, gangrene No infection	Superficial Localized Extensive	No operation Low amp. (below knee) Amp. above knee
Mixed, 3 plus vascular	Marked arterial deficiency Infection	Marked P.V.D. Initial lesion, gangrene Infection superimposed	Spreading	Amp. urgent (sulfa drugs, penicillin, anti-biotics)
Mixed, 2 plus vascular	Moderate arterial deficiency Infection	Moderate P.V.D. Initial lesion, infection Gangrene secondary	Spreading	Amp. urgent (sulfa drugs, penicillin, anti-biotics)
Mixed, 1 plus vascular	Slight arterial deficiency Infection	Slight P.V.D. Initial lesion, infection No gangrene	Superficial Localized Spreading	No operation Incision, drainage, amp. of toe Amp. at calf urgent (sulfa drugs, penicillin, anti-biotics)
Purely infectious	No arterial deficiency Infection	No P.V.D. Initial lesion, infection No gangrene	Superficial Localized Spreading	No operation Incision and drainage (sulfa drugs, penicillin, anti-biotics) Incision and drainage urgent (sulfa drugs, penicillin, anti-biotics)

*P.V.D.—Peripheral vascular disease.

Fig. 1. Purely vascular lesion (extensive). Marked impairment of circulation, gangrene, no infection.

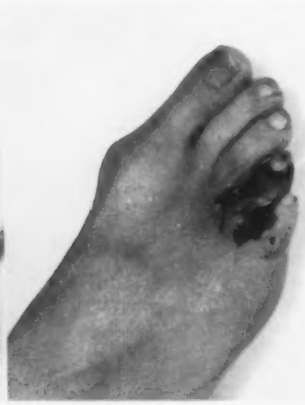

Fig. 2. Purely vascular lesion (localized).

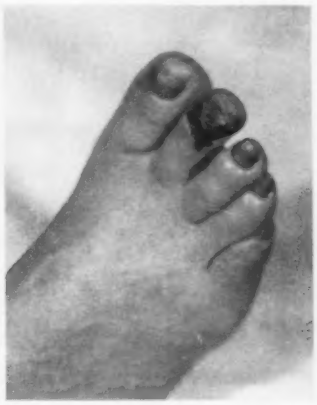

Fig. 3. Purely vascular lesion (superficial).

a gangrene. This we term a 1-plus vascular mixed lesion (Fig. 6). Now the purely infectious lesions, or the 4-plus infectious lesions as we call them, are characterized by none of the signs of arterial insufficiency. The initial lesion is an infection and there is no gangrene (Fig. 7). The next logical question one asks is, "This is all very true and very interesting and readily followed, but how does one determine marked, moderate, mild and none—in degree of arterial circulation?"

Clinical Procedure

This is a portion of our presentation which we feel is very important because this can be arrived at clinically. We do not depend upon oscillometers, geiger counters and radioactive indicators at all. Actually we examine the leg. The diagnostic criteria for our examination of the leg are listed in Table II. Table II is an outline of the precedure of clinical examination by which we determine the degree of arterial impairment and the severity and extent of infection. Under the column marked "Signs and Symptoms" we have tabulated the clinical observations made routinely in our cases. These include systemic and local findings.

The important systemic findings are age, evidence of arteriosclerosis in radial, retinal and coronary arteries, concomitant disease and systemic manifestations of the presence of infection. The local findings include all of the clinical observations of the lesion of the foot and the leg for the consideration of the vascular impairment and the extent and degree or intensity of infection.

In the center of Table II there is a col-

umn noting character of observation, whether it is a vascular or an infectious consideration (see footnote Table II). These observations have been cross-tabulated individually against the right hand ments, to arrive at a definite conclusion as to the degree of arterial insufficiency, the severity and the extent of the infection.

It is to be noticed that the x-ray findings are

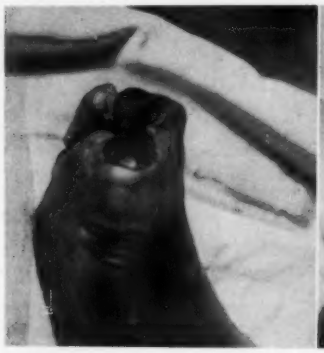

Fig. 4. Three-plus vascular mixed lesion. Marked vascular impairment, initial lesion gangrene, superimposed infection.

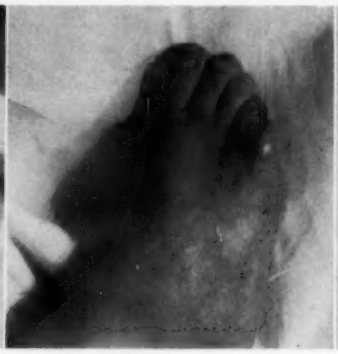

Fig. 5. Two-plus vascular mixed lesion. Moderate impairment of circulation, initial lesion infection, swelling causes compression of circulation, a superimposed gangrene.

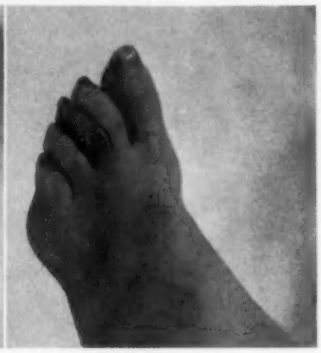

Fig. 6. One-plus vascular mixed lesion. Slight impairment of circulation, lesion infectious.

Fig. 7. Purely infectious lesion. Circulation good, lesion infection in a diabetic patient.

five columns "Classification of the Lesions" (which shows the five classifications of the lesions). In the vertical columns under each of the classifications of the lesions, we have tabulated an adverb of degree giving a conception of the frequency of the occurrence of the finding. Now if one reads each column of the classification of Table II from above down, under each column one reviews a series of clinical observations and these form a definite clinical concept in the mind of the examiner, which at the termination has developed into a concept of this class of lesion. (Take the time to read all five classes of lesions and one will clarify his clinical background.) In this manner, we feel that after these years of application we are still able clinically, without instru- tabulated as the last finding of our clinical observation of the patient and the leg. This we feel is the proper place for the x-ray findings because calcification casts only a shadow on the x-ray, but the shadow cast on x-ray gives the examiner no concept as to the adequacy of the collateral or to patency of the lumen which may still be present within a calcified vessel. We feel that too often the error is made that a diabetic with a lesion of the foot has an x-ray taken, calcium shadows are found, and an amputation is done high up. This is a typical mistake which we hope the thorough use of the classification will avoid.

Guide for Therapy

The classification which is offered for lesions of the lower extremities in diabetic patients, is clinically arrived at and has value in use as a guide for therapeutic indications. The value as a guide for therapeutic indications is based upon two principles of the classification. The first and most important principle is that surgery can only be done at a level where the arterial circulation is competent to cope with the trauma of the surgical procedure anticipated. The second principle is the degree of infection entering the lesion and how much one can depend upon our modern armamentarium of antibiotic and chemotherapeu-

TABLE II.

TABULATION OF THE DIAGNOSTIC CRITERIA IN THE LESIONS OF THE LOWER EXTREMITIES IN DIABETES

	Signs and Symptoms			*	Classification of the Lesions				
					Vascular	Mixed			Infectious
					"Four Plus" Purely	"Three Plus Vascular"	"Two Plus Vascular"	"One Plus Vascular"	"Four Plus" Purely
Systemic	Age		over 55 years	V	usually	usually	frequently	occasionally	rarely
			under 55 years	I	rarely	rarely	often	frequently	usually
	Concomitant disease		cerebral sclerosis	V	usually	usually	frequently	rarely	very rarely
			coronary sclerosis	V	usually	often	frequently	occasionally	occasionally
			kidney lesion	V-I	nephrosclerosis	nephrosclerosis	nephritis	nephritis	nephritis
			cystitis	I	often late	often	often	occasionally	not rarely
			metastatic abscess	I	never	rarely	occasionally	occasionally	occasionally
	Vascular evidence		arcus senalis	V	usually	usually	occasionally	never	never
			retinal sclerosis	V	usually	usually	often	often	rarely
			radial sclerosis	V	usually	usually	often	rarely	never
			"E.K.G." changes	V	usually	usually	often	often	occasionally
	Infectious evidence		temperature	I	never	usually	usually	usually	always
			pulse rate	I	normal	increased	increased	increased	increased
			leucocytosis	I	normal	increased	increased	increased	increased
			blood culture positive	I	never	often	often	occasionally	occasionally
Local	Lesion		gangrene	V	always	usually early	often late	rarely late	never
		Infectious	redness	I	none	always	always	always	always
			swelling	I	none	frequently	usually	usually	usually
			heat	I	none	usually	usually	usually	usually
			fluctuation	I	none	rarely	frequently	frequently	frequently
			discharge	I	none	rarely	usually	usually	usually
		Pain	claudication	V		usually	rarely	very rarely	never
			"night pain"	V	usually	usually	occasionally	rarely	never
			throbbing	I	usually	frequently	frequently	often	usually
			"bone" lesion	I	never	occasionally	occasionally	occasionally	occasionally
		Nourishment nails	transverse lamination	V	rarely	usually	often	rarely	never
		Skin	elasticity	V	usually				
			dryness	V	lost	lost	diminished	normal	normal
			atrophy	V	markedly	markedly	moderately	slight edema	edema
			absence of hair	V	markedly	markedly	moderately	slight	absent
					markedly	markedly	moderately	rarely	normal
		Muscle and fat	atrophy	V	markedly	markedly	slightly	none	none
		Lymphatics	ducts infected	I	absent	frequently	often	occasionally	occasionally
			enlarged glands	I	absent	frequently	often	occasionally	occasionally
			tender glands	I	never	frequently	often	occasionally	occasionally
	Foot and Leg	Arterial, Thickening	femoral	V	markedly	markedly	moderately	mild	never
			popliteal	V	markedly	markedly	moderately	mild	never
			dorsalis pedis	V	markedly	markedly	moderately	mild	never
			posterior tibial	V	markedly	markedly	moderately	mild	never
		Arterial, Pulsations Diminution	femoral	V	markedly	markedly	moderately	none	none
			popliteal	V	markedly	markedly	moderately	none	none
			dorsalis pedis	V	absent	absent	markedly	slightly	none
			posterior tibial	V	absent	absent	markedly	slightly	none
		Surface temperature		V-I	cold	infectious heat	infectious heat	infectious heat	infectious heat
		Vein refilling		V	prolonged	prolonged	slowed	normal	normal
		Color changes	elevation pallor	V	marked	marked	mild	no change	no change
			rubor dependency lividity	V	extensive	extensive	limited	slightly	no change
		Capillary circulation		V	delayed	delayed	fair	fair	good
		Wound culture	staphlococcus	I	negative	occasionally	frequently	commonly	commonly
			streptococcus	I	negative	commonly	commonly	occasionally	occasionally
			B. coli	I	negative	rarely	rarely	frequently	frequently
			B. welchii	I	negative	may occur	may occur	may occur	may occur
		Xray findings	calcified vessels	V	usually	usually	frequently	rarely	never
			bone necrosis	I	rarely	rarely	occasionally	frequently	often

*Character of observation: V—vascular observation; I—infectious observation.

tic control. With these two fundamental principles as a guide to therapy, in the light of our classification, we have established a guide for therapy in all of the lesions.

The purely vascular lesions, when they are superficial, require no operation and can be followed with conservative therapy as long as the gangrene does not extend and the lesion does not develop a superimposed infection. The purely vascular lesions that extend beyond the toe or into the web space, are known as localized gangrenous lesions and must have a modified guillotine amputation between the ankle and the knee in the absence of spreading infection. In the purely vascular lesions that are extensive, the amputation must be done above the knee, and, in our experi-

ence, a modified guillotine or step-amputation can safely be done at the supracondular level. We see no advantage in the use of a mid-thigh amputation.

In the mixed lesions the indicated therapy is:

The 3-plus mixed lesions (those with arterial insufficiency marked with a superimposed infection) are more urgent and if antibiotic and chemotherapy has not controlled the spreading infection or the spreading gangrene, then an urgent amputation is indicated and most often at the supracondular level, rarely below the knee.

The mixed lesions, which we call 2-plus vascular mixed lesions (those with moderate arterial circulatory impairment together with an infection and often a secondary gangrene) require some little judgment. However, in the presence of modern chemotherapy and antibiotic therapy, the infection can be so controlled and, with only moderate impairment of arterial circulation, the amputation can very often be done successfully with a modified guillotine technique at a level below the knee or mid-calf.

The mixed lesions, which we classify as 1-plus vascular mixed lesions (those with slight arterial circulatory impairment in which the lesion was initially an infection and in which no gangrene is present), can be classified again as the superficial, localized and extensive types. In the superficial type the indicated therapy calls for no operation, but does require antibiotic therapy and patient waiting. In the 1-plus mixed type, where the lesion is localized, there can be attempted incision and drainage and amputation of a toe, provided there is no evidence of gangrene. If the infection is more extensive in spite of the antibiotic and chemotherapy, then lower leg modified guillotine amputation is indicated.

Finally, in the purely infectious type of lesion, where there is no clinical evidence of arterial circulatory impairment, and if the lesion is superficial, conservative treatment and no operation is indicated. If the lesion is localized, incision and drainage and sulfa and antibiotic therapy is indicated, and, if the lesion is spreading, early incision and drainage and diligent and intensive sulfa and antibiotic treatment is definitely indicated. In these purely infectious lesions rarely is amputation indicated, except amputation of a toe to "pie-cut" a foot and adequately drain infection.

But the key here is: Can the arterial circulation cope with the trauma of the surgical procedure? Nowadays, in the face of our modern anti-infectious treatment, many of these cases can be subjected to this treatment successfully. These recommendations have definitely and specifically applied the two principles aforementioned. The first is, infection can be controlled by sulfa and antibiotic therapy, by selection and care regarding sensitivity tests. The second is, the surgical procedure indicated must be judged and the level determined by a careful estimation, clinically, of the circulatory state of the leg. Surgery must be done only at a level where the circulation is adequate to cope with the trauma of the surgical procedure.

Conclusion

In conclusion, we have attempted to present our evidence to show that the surgical lesions involving the extremities in diabetic patients can be classified clinically without instrumental apparatus. We have tried to show that in the light of this classification, arrived at by careful physical examination of the patient and the leg, these lesions so-classified, can be treated conservatively. We have attempted also to present the application of this classification as a guide to the therapy. We have attempted to show, in view of our present-day knowledge of anti-infectious therapy, that this classification can be a guide to conservative therapy in legs where the circulation is only moderately or slightly impaired, or show no impairment. However, we wish to show and state definitely that when the arterial circulatory impairment is such as to be moderate, marked or severe, and the lesion is a gangrenous lesion dependent purely upon the element of arterial circulation, then amputation is indicated.

Also we have attempted to show that this classification can be used as a guide regarding the level of amputation in an attempt to avoid repeated amputation—the principle involved being that the amputation can be done only at the level where the arterial circulation is adequate to cope with the trauma of the surgical procedure. This definitely is true, we feel, and is presented as a result of nineteen or twenty years of experience in applying the classification to these kinds of lesions. All of this presentation, however pre-

(Continued on Page 983)

Some Problems of Gerontology

By William B. Kountz, M.D.
St. Louis, Missouri

PERHAPS ONE of the greatest problems of gerontology is its complexity. This complexity causes it to be involved with many different fields of human thinking, and since thought patterns are generally divided into disciplines which add up to the total unit of any problem, we find it difficult to bring together the units for a composite picture of the whole. Thus, the social, medical, biological, economic and psychological aspects are all units of the larger problem of gerontology. However, by far the most important are the medical and the biological aspects, which lead to a clearer understanding of health. They will keep the individual from the diseases that are so frequently associated with years, and thereby making him able to maintain his place in society.

No one would deny that in our present society the different disciplines are so interrelated that they influence one another, and perhaps the problem of ill health comes in for more than its proportionate share. For example, the economic aspect may modify the psychology and the physical state in different ways and cause disease to occur. It is thus important that physicians treating older people evaluate not only a single aspect of the older person, such as the clinical status or the psychology alone, but also the social and other aspects of the individual's existence in order to accrue proper values for therapy.

On this program we must limit our remarks to the clarification of thinking in the field of medicine. This requires the answers to certain questions. One question that needs understanding is: what relation do the common degenerative diseases, associated with the period of midlife and beyond, have to actual aging in years? Formerly it was considered that the degenerative diseases were directly related to age, that it was impossible to turn back time, and, therefore, such conditions were inevitable parts of human existence—perhaps like death and taxes. Only in recent years has clarification of the problem been sufficient to establish that the diseases past midlife, although commonly occurring in older persons, are not a necessary concomitant of growing older. Medical experience has shown that the child with the early-aging syndrome, or so-called progeria, will have the same characteristics and clinical picture as seen in older people. He will die at an early age, in his teens or earlier, with such diseases as coronary thrombosis, heart failure, etc.: the diseases that are so commonly associated with older people.

The development of knowledge of the physiology of the human body, and the amplification of certain factors, have established that the so-called degenerative diseases are probably nutritional in origin. This concept brings up the relationship of various nutritional functions of the body, such as the glands of internal secretion, as well as the nutritional function of other tissues. It also involves the problem of food intake and an understanding of its influence on the human mechanism. Such substances as different types of fats, the lack of certain vitamins, and, more recently, the problem of trace minerals have come into view. In addition, the understanding of stress and strain and the realization that stress within itself will produce definite nutritional disturbances are important. The realization that nutrition and disturbed metabolism of the body may be the cause of degenerative disease makes a more rational approach to the study of health past midlife. In other words, there is a realization that disease changes are the results of exhaustive phenomena that may be corrected, rather than of the addition of years, for which nothing can be done.

A recent article by Dr. Charles D. Marple, Medical Director of the American Heart Association, emphasizes that much of our medical research is not geared to fundamental facts. Dr. Marple emphasizes that there is a parallelism between changes that occur with aging, which is not age, and the increase of cardiovascular disease, of which high blood pressure, arteriosclerotic heart disease and cerebrovascular lesions are the com-

Presented at the Michigan Clinical Institute, Detroit, March, 1957.

mon afflictions. He further states that the control of the diseases of the blood vessels does not lie with study of the blood vessels alone, but with study of the scientific problems and facts of age changes, with no single aspect of the problem completely independent. He states that all facets of the problem of aging should be considered, and scientific progress at all levels of the phenomena must be followed in order to develop a complete program.

The recent work on physical or emotional stress and its relationship to the development of heart disease emphasizes that disciplines other than biology must be considered in the control of degenerative disease. Therefore, there is a need for physicians, particularly, to realize that we must encourage and demand that our scientists study the fundamentals of medical research rather than, shall we say, a study on simple heart disease or cancer or arthritis. Physicians should insist upon, and try to obtain always, a better understanding of the physiology of the human mechanism as it grows older.

So much, then, for the problem of the relationship between common diseases associated with midlife and beyond and the process of aging. We would say that it is clear that they are associated, but that age in years plays little if any part in the formation of ill health.

The next problem we must clarify is the possibility of whether medicine can modify the course of diseases that are commonly associated with older people. Since medical thinking is primarily in terms of anatomy and we think of disease and change in these terms rather than in the functional aspect of tissue, let us review some of the restorative changes that have been seen in the older organism.

One can say with definite certainty that anatomical and functional changes may be brought about and a tissue returned very much more nearly to normal if proper stimulation is applied, to which the tissues respond. Since there is a need for a better understanding of the physiology of the body and its application to the older person, it becomes necessary for us to review some of the physiological changes that occur with time, which give evidence that they may lead to the degenerative diseases which we hope to control.

One may conclude that, parallel with age, there are certain changes in the body function and especially in the glands of internal secretion which modify the metabolism, the nutrition, and doubtless contribute to the occurrence of degenerative diseases. Proof of such changes has been developed in relation to the problem of thyroid function. Prolonged thyroid inactivity leads to a low iodine level and disease of the blood vessels.

Deficiencies of the estrogen groups have been shown in the experimental animal, particularly the chicken, to lead to coronary artery disease. Perhaps the most important disturbance of estrogen deficiency in the body has been shown by Korenchevsky to be decreased permeability of all tissue membranes. This decreased permeability leads to poorer nutrition, a change in fluid balance and mineral balance in all the cells. The depletion of the androgenic substances from the body leads to a loss of body protein. Since one of the characteristic changes in individuals past forty is a loss of calcium and protein in the body resulting in senile changes, the use of the sex hormones must be emphasized.

Thus, the studies of body changes emphasize that the hormones play an important part in the nutrition of the body of the older person. The present indications are that most degenerative disease changes are related to disturbed nutrition, and it is therefore logical to assume that a common relationship may exist. It has been shown that certain hormone substances have an ability to protect the body, particularly from the standpoint of repairing and conserving protein. These substances include the androgens, the thyroid, insulin and estrogen, depending upon the need of the individual for the particular hormone. On the other hand, cortisone and corticotropin cause mobilization of tissue substances, particularly proteins, and tend to increase body tissue loss and accentuate the aging process by acting like stress factors. Since stress is a common feature of life, whether physiological, psychological or physical, protection by hormones is very important.

Therefore, not only is proper diet necessary but proper clinical evaluation of individuals must be made in order to establish the combination of hormone substances needed in the body. When any lack is met and supplied, health and the prevention of body deterioration occurring with age are facilitated.

Time will not permit us to go into specific treatment of individuals; we can only give you a

consideration that whatever is needed to bring the body function toward normal is important in therapy. Hormone substances have a definite place but they vary from individual to individual. These all may and should be measured when therapy is anticipated: the thyroid by various techniques, the androgen content of the body by nitrogen balance studies, the estrogen content of the blood, the adrenal cortex by 17-ketosteroids, etc. The question of other substances, such as the vitamins and minerals as well as the newer tranquilizing drugs, must also be considered.

The older person generally needs supplementary feedings and administration of different vitamins. It has been found that some individuals need a relatively higher intake level particularly of vitamin A, vitamin D, thiamine, ascorbic acid, riboflavin, than most will take in by food. It is interesting that many individuals, even though their blood levels may be adequate for these various substances, will respond to supplementary administration. Another factor of importance is the trace minerals which have been found to have a definite function within the body. Copper, cobalt, zinc, and iron, particularly, should be kept on the positive side. As you know, copper has to do with the oxidative enzymes, whereas zinc has to do with the formation of carboxylase, which is involved in the respiration and the proper elimination of CO_2 from the body.

I wish to emphasize the need for attention to the evaluation of older people. We have called your attention to the fact that the older person varies in his physiological response and in the nutritional aspect. These differences reflect a need for understanding of the different responses in evaluation of health. Thus, in the younger person the health reserve is sufficiently broad that one may only consider disease, but in the older person the health reserve has narrowed, and not only is it important to study the disease process which may be presented but also to evaluate the health reserve whenever possible. With this need for a different approach to the study of the physiological mechanism of the body in mind, therefore, one should not only evaluate the individual at one single time, but also study the reserve physiology. As an example, in a study of diabetes one should not simply take one blood sugar which may be normal, but one should also do a glucose tolerance test. One should not take simply an electrocardiogram of the heart, but one should also study the function of the heart by means of a chest x-ray, kymogram, and exercise tolerance test, all of which serve to indicate not only the presence of disease but the degree of potential health that is present. This applies to all important body tissue functions. Since aging is like growing up, patterns are developed and thorough evaluation once every five or six years with clinical follow-up perhaps once or twice a year will enable one to control the health of people past midlife.

Much can be done in the control of health past midlife. A number of patients have been followed over a period of years to ascertain the value of an attempted control of the health problem. Those individuals who had a low iodine uptake and evidence of hypothyroidism were given thyroid and iodine. Those who had evidence of low estrogen and androgen were likewise given the necessary substances. Those who showed an insulin deficiency were controlled by diet and insulin. The diet given the individuals was adjusted to what was considered their needs. None was pressured to participate in the study. The percentage of illnesses or increased degenerative changes that had developed was noted. Projection of the health factor on the treated versus the untreated individuals in the study suggests that at least twenty years of health and life may be added to individuals who are thus properly controlled from a medical standpoint.

SURGICAL LESIONS IN DIABETICS

(Continued from Page 980)

sumes that the diabetes is under control and that the diabetic patient is in good nourishment before, during and after the operation.

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Massive Cerebral Hemorrhage Complicating Toxemia of Pregnancy

By Bernard Levine, M.D.
and Murray Hess, M.D.
Oak Park, Michigan

MASSIVE cerebral hemorrhage in pregnancy occurs under two types of circumstances. It occurs either as a complication of a hypertensive state or in an apparently normal patient. In this latter category, it is usually the result of a congenital anomaly or an aneurysmal dilatation of a cerebral vessel. This type occurs much less frequently, there being only thirty-one cases reported in the literature. The following classification of cerebral hemorrhage complicating pregnancy is suggested:

I. Cerebral Hemorrhage in Otherwise Uncomplicated Pregnancy
   (a) Aneurysm
   (b) Congenital vascular anomalies (Occurs before thirty-six weeks)
   (c) Undetermined (Occurs at delivery or postpartum)
II. Cerebral Hemorrhage as a Complication of a Hypertensive State
   (a) Chronic hypertension
      1. Essential hypertension (After thirty-six weeks)
      2. Chronic nephritis (After thirty-six weeks)
   (b) Acute hypertension
      1. Toxemia (After thirty-six weeks)
      2. Oxytoxic drugs (At time of use)

Dr. Harold Mack[7] has recently suggested a grouping of cerebral hemorrhage in accordance with the time of their occurrence in pregnancy. This is of particular practical importance since it not only gives an excellent indication as to the probable etiology of the hemorrhage, but also indicates which cases might benefit from surgical repair of the ruptured vessel.

Goodfriend and Klein[5] reviewed all the cases of cerebrovascular hemorrhage which occurred on the Obstetrical Service of Morrisania City Hospital (New York) from 1930 to 1948. In 25,000 deliveries, there occurred five such cases—an incidence of one in 5,000 deliveries. In this series, only one of the five survived.

Donnelly and Lock[4] reviewed the cause of death in 533 fatal cases of toxemia. They found marked cerebral disturbances in 33 per cent of patients whose deaths were attributed primarily to toxemia. In view of the fact that Abbott[1] states that cerebral hemorrhage of various sizes is a frequent occurrence in eclampsia, since he found it present in 40 per cent of autopsy material, it is probable that all toxemic patients who displayed marked cerebral symptoms have some degree of cerebral hemorrhage. In Donnelly's series, of all deaths from toxemia, 17 per cent exhibited gross evidence of cerebral hemorrhage such as hemiplegia or bloody spinal fluid. If we were to use the survival rate of one in five as reported by Goodfriend,[5] then, the incidence of gross cerebral hemorrhage in toxemia would be about 20 per cent. Sheehan's information is in agreement with Donnelly since he reports that one-third of the patients who die of eclampsia exhibit macroscopic evidence of hemorrhage in the brain at autopsy. Kosmak likewise states that some degree of cerebral hemorrhage is found at autopsy in most eclamptic deaths. Parks[8] reviewed cerebral complications in toxemia. Of 1,009 patients with clinical evidence of late toxemia, there were seven maternal deaths. Four of these deaths showed gross evidence of cerebral hemorrhage. Cannell[2] analyzed all cases of subarachnoid hemorrhage in females over a six-year period. Of these cases of hemorrhage, 25 per cent occurred during pregnancies.

It is significant that the pre-existing condition of the patient is important to the development of cerebral hemorrhage. In the Goodfriend series, all patients had a previous hypertensive condition and developed a superimposed toxemia prior to the cerebrovascular accident. Parks also found that chronic hypertensive vascular disease preceded the development of toxemia and cerebral hemorrhage in three out of four fatal cases of eclampsia.

The time of occurrence of the hemorrhage shows a relationship to the etiology of the vascular accident. In those instances where the cerebral hemorrhage is of congenital origin, about 60 per cent occurred in the first twenty weeks of preg-

From the Department of Obstetrics and Gynecology, Highland Park General Hospital, Highland Park, Michigan.

nancy and 80 per cent occurred in the first thirty-six weeks. In this group, 50 per cent were from aneurysms, 25 per cent from arteriovenous malformations, and 25 per cent from undetermined causes. Conley[3] found that of those cases of cerebral hemorrhage in the non-toxemic group that occur after thirty-six weeks the cause is invariably undetermined. In contrast to this, in the category of toxemia, about 54 per cent occurred during and shortly after delivery with about 80 per cent commencing after the thirty-sixth week. Goodfriend reported that in all of his cases the gestation was over seven-and-a-half months at the time of the hemorrhage.

Grossly, bloody spinal fluid is diagnostic of hemorrhage which has either originated in the meninges or has extended from the brain into the ventricles or subarachnoid space. If cerebral hemorrhage is sudden and extensive, all motor pathways may be blocked preventing convulsions. In the only series in which this was reported, convulsions occurred in 50 per cent of cases. The most common neurological sign was hemiplegia which was noted in 80 per cent of cases. Symptomatology is quite constant, headache of occipital distribution being the most common. Other common signs are nuchal rigidity and loss of consciousness. In about 30 per cent of cases, circulatory collapse and unconsciousness is the first warning of anything abnormal. The physiopathologic signs and symptoms are exactly the same as those of eclampsia—namely, headache and/or coma and convulsions, albuminuria and hypertension. The one differential point lies in the bloody spinal fluid; however, an interval of time must elapse between the time of hemorrhage and the time of the tap or this differentiating point will be lost.

There is no sign which is considered of prognostic value in cerebral hemorrhage of toxemic origin. In hemorrhage of congenital origin, the presence of coma is of prognostic value. Of the cases in which this was reported, three out of four women with coma died while there were no deaths where coma was absent.

Patients who have once had a cerebral hemorrhage should be evaluated carefully as to the advisability of future pregnancies. The consideration of a subsequent pregnancy does not involve the question of toxemia but is decided primarily on the type, extent, and etiology of the previous hemorrhage and the amount of residual neurological involvement. From the limited cases studied, it is believed that if the origin of the hemorrhage is from a congenital anomaly which has been repaired surgically then there is little contra-indication to a subsequent pregnancy. If the hemorrhage was treated non-surgically, and there is no chronic hypertension, then pregnancy would be relatively safe, but, at the first indication of hypertension, the pregnancy should be terminated. However, if cerebral hemorrhage is a complication of a chronic hypertensive state, then further pregnancies are contra-indicated.

There are cases reported where the use of oxytoxic drugs have been implicated in the precipitation of cerebral hemorrhage. Since pituitary extract and ergotrate are used widely, it should be stressed that serious toxic reactions may result from their use. Either may precipitate cerebral hemorrhage or mimic eclampsia. It was found that the most marked response to posterior pituitary extract was obtained in the pre-eclamptic group. It has been found that the vaso-pressor action of these drugs is enhanced when its use is preceded by adrenalin or ephedrine. Ergotrate preparations should not be used in patients who have received vaso-pressor drugs or in the presence of hypertension. This is particularly true in the toxemias. There may occur under those circumstances, an adverse summation of action with a resultant critical hypertension and cerebral hemorrhage.

The following is a report of a case of massive cerebral hemorrhage as a complication of toxemia:

A white woman, aged twenty-two, gravid 2, para 0, was admitted to the obstetric service on Jan. 14, 1956 at seven months gestation because of premature rupture of membranes and onset of labor. The patient had been seen by her physician for routine prenatal examination ten days prior to her admission at which time her blood pressure was 118/76, urine negative, and weight 105 pounds (weight prior to pregnancy 89 pounds). Patient's pre-natal course prior to this was uncomplicated. Past history was non-contributory.

On admission at 12:30 a.m., the physical examination was negative except for a blood pressure of 200/110 and a 4 plus albuminuria. At 1:20 a.m., rectal examination showed the cervix dilated 3 cm. and slightly effaced, and the presenting part at mid-pelvis. She was given Seconal gr. III orally which she vomited. She was then given Na Amytal gr. 3¾ I.M. At 2:20 a.m., the patient complained of mild headache. At 2:40 a.m., the patient was seen by the attending physician who noted a complete lt. hemiplegia. Blood pressure was 160/90. Dilatation at this time was 5 cm. and effacement 80 per

cent. Obstetrical consultation recommended vaginal delivery as soon as the dilatation was complete. Neurological consultation was in agreement that delivery should be as soon as possible. Spinal tap showed grossly bloody spinal fluid. At 3 a.m., dilatation was 8 cm., 80 per cent effaced, and at plus 2 station, at this time patient had first convulsion. At 3:45 a.m. dilatation was complete, and patient was taken to the delivery room. At this time, she had a second convulsion. Under pudendle block and oxygen inhalation, patient spontaneously delivered a stillborn infant weighing 2 pounds, 15 ounces.

For the next eight hours, the patient had several convulsions which were each controlled by I.V. Na Amytal. The patient also developed acute cardiac failure and pulmonary edema which required digitalization. Her condition remained relatively unchanged until the third postpartum day when diuresis began, and the patient regained consciousness and was able to eat and to talk rationally. With the exception of the hemiplegia, the patient recovered sufficiently to be discharged on the twelfth postpartum day to convalesce at home. The hemiplegia gradually improved and in January, 1957, at which time the patient was last seen, there had been total recovery with the exception of a very slight left sided muscular weakness.

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CORONARY DISEASES AND ANGINAL SEIZURES

(Continued from Page 975)

for routine use. Nitroglycerin may be continued as needed although its use can usually be eliminated within a short time.

Kelid is the most successful form of therapy we have used in angina pectoris. It deserves clinical trial in patients with the anginal syndrome, and the possible long-term myocardial improvement which it may effect should receive further study.

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Laparotomy Following Abdominal Pregnancy

By Bernard Levine, M.D.
Oak Park, Michigan

IN OUR paper published in the February, 1957, issue of THE JOURNAL of the Michigan State Medical Society, we reported two new cases of advanced abdominal pregnancy. This is a supplemental report concerning one of those cases, and is being submitted because it represents new information regarding one aspect of abdominal pregnancies which has not been previously reported.

From the literature it was ascertained that the opinion was widely held that it was safest to allow the placenta to remain intact and undisturbed when delivering the baby from the abdominal cavity. This, we feel sure is the case, but there has been lacking accurate information relative to the course of events pertaining to the placenta in cases managed as indicated above. It is known that the placenta may become involved in an infectious process with abscess formation which may require surgical drainage. But where no complications existed it was believed that the placenta underwent a gradual process of absorption and that this process was completed in less than two years. This viewpoint was substantiated by the few cases which required abdominal surgery for other reasons subsequent to an abdominal pregnancy. In these cases no evidence of remaining placental tissue was noted and no pelvic or abdominal complications arising from the placenta occurred.

In our *Case 1,* the patient began to have lower abdominal pain referable to an adnexal mass and underwent a laparotomy four years after the delivery of the fetus with the recovery of almost all of the placenta excepting a small portion which had been absorbed. This is believed to be the only such instance reported as is the photograph of the gross specimen (Fig. 1).

Supplemental Case Report

The patient was again seen in early 1957 because of episodes of right adnexal pain. Examination revealed a painful mass in this region. The possibility of an inflammatory condition was considered and the patient was given antibiotic treatment which elicited no appreciable change in her condition. She was seen again one month later. Her symptoms were much the same but the mass felt somewhat larger. Surgery was done in June, 1957. Pelvic exploration revealed a large, indurated, partially necrotic, irregular mass primarily in the region of the posterior leaf of the right broad ligament with some extension to the uterus and lateral pelvic wall. There were no extensive adhesions and the dissection was accomplished with ease and with no bleeding. The normal gross structure of the adnexa was completely destroyed. The patient made an uneventful recovery and left the hospital in six days.

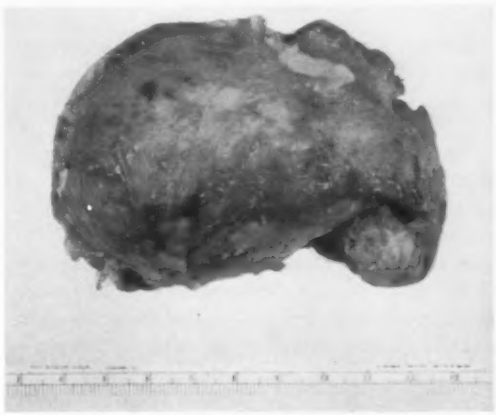

Fig. 1. The necrotic area is seen in lower right. Ridge on top is believed to be remnant of tube.

Although this information should not alter the previously stated management regarding the placenta, it should be kept in mind that failure of absorption of the placenta may be the origin of future symptoms.

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Obstetric Hemorrhage

By C. Paul Hodgkinson, M.D.
Detroit, Michigan

HEMORRHAGE, for this presentation, is defined as abnormal bleeding from the internal pudendal vascular system, including the utero-ovarian axis, incident to or as the result of pregnancy and its cognate functions. It occurs for three reasons: (1) a break in the continuity of the vessel walls; (2) lessened efficiency of the mechanical hemostatic power of the myometrium; or, (3) deficient blood coagulation.

Potential for Hemorrhage

Pregnancy is accompanied by local changes which highly favor the chance for hemorrhage of massive proportions. Beginning with conception and ending with delivery, there occurs a reorientation of vascular dynamics. With the homeostatic balance dominated by the demands of the developing fetus, blood is directed to the site of implantation in an ever-increasing volume. By the physiological processes of hypertrophy and hyperplasia, the pelvic vascular system regularly accommodates to a blood volume calculated to increase more than sixty-six times.[1] With this segment of the vascular system burdened with an augmented blood volume of this magnitude, hemorrhage of cataclysmic proportions looms as a constant threat.

Nature has provided safeguards. The circulating blood volume is increased. Some of the constituents of the coagulation mechanism, particularly plasma fibrinogen, are increased in concentration. The clotting time is usually shortened. Anatomical and physiological factors combine to damp off venous and arterial pressures to levels safe for retroplacental circulation.

Although the vagina and the lower uterine segment must depend upon the coagulation of blood for hemostasis and the arrest of hemorrhage, the uterine fundus gains added hemostasis from myometrial contraction. It is a curious and propitious anatomic fact that neither the ovarian nor uterine arteries directly enter the uterus. Arising from the laterally-placed utero-ovarian arterial axis, blood gains access to the endometrium through secondary arteries which traverse the interstices of the intertwining myometrial fibers. By this anatomic arrangement and because of the power of the myometrial fibers, arterial blood can largely be excluded from the puerperal uterus. Eastman[2] likened this phenomenon to the action of living ligatures, and declared it to be the most important fact in obstetrics (Figs. 1 and 2). Comparison of the utero-ovarian vascular pedicle before and after extraction of the infant by cesarean section dramatically demonstrates the effects of this powerful hemostatic property.

Obstetric hemorrhage strikes with unpredictable incidence and frequency. If hemorrhage is to be toppled from the pinnacle of causes of maternal death, improved diagnosis must be coupled with improved treatment. Transfusable blood has been made more readily available to a larger segment of the population through the untiring efforts of those concerned with blood bank programs. Yet patients continue to die of obstetric hemorrhage when they are figuratively "bedded-down" beside well stocked blood banks.

Too frequently the cataclysmic proportions of obstetric hemorrhage are not appreciated. That sudden death may occur in a matter of minutes is exemplified by the syndrome of spontaneous intraperitoneal rupture of the utero-ovarian veins. Over 75 per cent of the patients reported have died when rupture of the veins occurred during labor. The time, from onset of symptoms to death, was frequently less than one hour. Postmortem studies have disclosed hemoperitoneum of over 3,000 cc. (volume). When the magnitude of the volume of blood carried in the pelvic vessels is contemplated, it is not difficult to understand how a rent in the wall of a blood vessel in the broad ligament could vent a hemorrhage of that size.

In placenta previa, factors other than the augmented blood volume are important. Here, orientation of vascularity to the placental site is an added onus. Because, in this area of the birth canal, hemostasis comes mainly from blood coagulation, unrestrained hemorrhage may issue from

From the Department of Gynecology and Obstetrics, Henry Ford Hospital.
Presented at the Michigan Clinical Institute, Detroit, March, 1957

the open blood sinuses after expulsion of the placenta. There also is an increased tendency for rupture of the lower uterine segment in placenta previa. The greatly thinned, highly edematous and friable retroplacental tissue may give way to the pressure of normal spontaneous delivery of the infant through the mid pelvis. This pathological event adds tissue trauma to the already high potential for hemorrhage, and occasionally critical fibrinogen depression of the fibrinogen-fibrin conversion syndrome may further complicate the enigmas of diagnosis and treatment.

In the uterine fundus, deficient myometrial hemostasis is a constant hazard. The open retroplacental blood sinuses are probably the most frequent sources of excessive blood loss after delivery. If arterial pressure can overcome the resistance offered by myometrial contraction, hemorrhage is likely to occur. A small hard uterus is the best clinical index of efficient myometrial contraction. Any factor which diminishes full contraction of each myometrial fiber tends to decrease uterine hemostasis. Myometrial fatigue from over-distention or prolonged labor, myometrial injury from uterine rupture, and the presence of intrauterine space-occupying bodies are some of the factors inimical to maximal contraction of myometrial fibers. The presence of placental fragments, hematomas, and intrauterine gauze packs lessen the salutary constricting influence of the contracting myometrium.

Hypofibrinogenemia may be a factor of importance in conditions other than abruptio placentae. Evidence has accumulated to indicate that the intravascular conversion of fibrinogen to fibrin is a fundamental physio-pathologic reaction to thromboplastinemia, secondary to cell trauma. Many acute catabolic influences such as abruptio placentae, long intrauterine retention of dead fetus, amniotic fluid embolism, surgical and accidental trauma, incompatible blood and fulminating eclamptic convulsions have the power to depress circulating fibrinogen.

It is important to appreciate that the syndrome of massive fibrinogen-fibrin conversion has dual pathologic potentialities: first, embolization, then hemorrhage. If the process is precipitous and massive, the symptoms are chiefly embolic; if more gradual, hemorrhagic.

Four general clinical types have been recognized: hyperacute, embolic (amniotic fluid embolism); acute, embolic-hemorrhagic (abruptio placentae); chronic hemorrhagic (dead fetus syndrome); and the delayed embolic (lower nephron disease of the kidney).

In obstetrics, the diagnosis should be suspected whenever shock and/or hemorrhage are evident. The diagnosis is easily confirmed, without detailed laboratory study, by the use of the "clot observation test." Five cubic centimeters of uncoagulant-treated blood should be observed at room temperature for clotting behavior. The disease is not present if the blood clots in eight minutes and shows normal retraction without evidence of lysis within one hour. The disease is probably present if a flimsy clot forms and undergoes lysis within twenty minutes. The plasma fibrinogen range is probably between 100 and 150 mgm. per 100 cc. of plasma in such circumstances. The disease is certainly present if no clot forms, indicating fibrinogen depression below the critical level of 90 mgm. per 100 cc. of plasma.

Treatment

The treatment of obstetric hemorrhage should be preplanned and aggressively executed. Therapeutic efforts can be categorized into three general disciplines: emergency, diagnostic, and definitive.

Measures of Emergency.—Prompt recognition is the first essential step. A newly delivered patient should be carefully observed by trained and experienced personnel. The blood pressure should be stabilized, the pulse should be less than 100 per minute, and the uterus firmly contracted and confined to a position in the lower abdomen, before the patient is permitted to be returned to her room.

When there is a suspicion of hemorrhage, observation of the patient should not be left to the student nurse or inexperienced intern. Too frequently a large volume hemorrhage may be entrapped between the vaginal introitus and the contracted uterine fundus with a gradually rising uterine fundus as the only significant symptom. The unwary observer fails to recognize the danger until one of experience manipulates the fundus and expels a hematoma of 500 to 800 cc. volume. Another disquieting finding is the continuous trickle of blood from the vagina. Too frequently and too quickly does this insidious blood loss assume dangerous proportions.

The second essential step of the measures of emergency is the initiation of a preplanned pro-

gram: an urgent call to the blood bank for 2000 cc. of perfectly matched, fresh whole blood; immediate institution of two intravenous infusions using large bore needles (15 gauge); intravenous administration of 5 per cent glucose solution containing 2 cc. (20 units) oxytocin* per each 1000 cc. at a rate of 20 to 40 drops per minute; appropriate uterine massage; head-down shock position on the delivery table; the administration of oxygen by face mask; and the mobilization of a team of competent assistants including an anesthesiologist, other obstetricians, a hematologist, a vascular surgeon and additional residents.

The utilization of nondefinitive emergency measures should be reserved for fulminating hemorrhage. Aortic compression, applied manually or by means of a spanish windlass, is better accomplished by direct application of a Potts aorta clamp applied above the level of the renal vessels. The experience of vascular surgeons has shown that such aortic pressure is tolerated for periods of time up to one-half hour. A Potts aorta clamp should be available in every delivery room. Measures of aortic compression are probably less traumatic than blindly clamping the uterine vessels from the vaginal approach.

Measures of Diagnosis.—The second stage of treatment is diagnostic. The general diagnosis of "obstetric hemorrhage" is too vague to be of practical value. Every effort should be made to qualify the diagnosis to a more specific category. It is important to remember that initially there may be one main reason for hemorrhage but as the condition of the patient deteriorates all three reasons may combine into one catastrophic state.

Blood for the "clot observation test" should be obtained at half-hour intervals and be under the surveillance of a competent observer. Undue trauma, mismatched blood, multiple blood transfusions, and plasma expanders have caused fibrinogen depression.

Re-examination of the patient should be accomplished under favorable conditions. This means on the delivery table with adequate assistance, exposure, good light, and sufficient and proper instruments. The vaginal walls and the cervix should be carefully inspected. Rents in the lower uterine segment may not extend through the cervical ring and may be difficult to locate, particularly when they extend into the broad ligament and not into the peritoneal cavity. The fundus should be explored for retained placental fragments and sites of rupture, both complete and incomplete.

Measures of Definitive Therapy.—Definitive therapy depends upon precise diagnosis. Vaginal lacerations are advantageously repaired using a continuous suture of No. 0 chromic gut. The suture should be started at one end of the laceration and worked toward the other. Traction on the suture helps expose the next area for placement of the needle.

In placenta previa, bleeding from the lower uterine segment may be exceedingly brisk. Only the most prompt and efficient treatment will be of avail. Tamponade through a large rolled towel placed in the lower uterine segment mediated by manual pressure from one hand placed in the vagina and the other placed on the abdomen over the uterine fundus, will be effective in most cases in arresting hemorrhage from the large misplaced blood sinuses.

Hemorrhage from the boggy, poorly contracted uterus is better controlled by efforts to stimulate more efficient uterine contraction than by the placement of an intrauterine pack. The administration intravenously of 10 cc of 10 per cent calcium gluconate has been found of advantage, as has been the inhalation of 100 per cent oxygen, for the patient whose uterus refuses to contract.

In patients suffering from hypofibrinogenemia, search for sites of trauma is essential. It is a well-known clinical fact that in the absence of laceration, patients whose blood is made completely uncoagulable by deficient fibrinogen or the administration of anticoagulants, may deliver without excessive hemorrhage so long as myometrial contraction can be efficiently maintained. Fortunately, the natural regeneration of fibrinogen is usually accomplished promptly. If the initiating cause for fibrinogen depression has been eliminated, as usually occurs with delivery in abruptio placentae and in the dead fetus syndrome, the fibrinogen will have recovered to safe levels within two hours.

Finally, sometimes a surgical procedure is necessary for patients suffering from critical fibrinogen depression. This may mean cesarean section for abruptio placentae or hysterectomy for trauma. The administration intravenously of 10

(Continued on Page 993)

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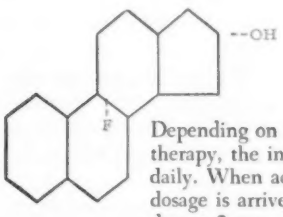

Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

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What Is Research?

By Willard C. Olson, Ph.D.
Ann Arbor, Michigan

IT is appropriate on this occasion to give special attention to research as an aspect of "Co-operation in the Study and Research of the Training, Care, and Prevention of Mental Retardation." We are certain in the period just ahead to have increased research activity. Thus, under Public Law 531, the 84th Congress of the United States made funds available to the Office of Education for co-operative research in mental retardation. The writer is serving as the co-chairman of the Research Advisory Committee, established to advise the Commissioner of Education in the evaluation of projects. Contracts made under this law have involved colleges and universities and state educational agencies.* They are concerned with problems of learning, growth and development, and social and emotional factors. Other agencies of government similarly have funds for the investigation of problems relevant to the medical and social fields or for the development of personnel. From a relatively small fund designed to cover many areas of research in the utilization of human resources, the University of Michigan has made some allocations to the study of problems of the mentally retarded. Proposals are under discussion for the preparation of increased personnel and a larger body of trained investigators. It is thus timely to ask the question, "What is Research?"

Research means many things to many people. The process consists in the orderly treatment of data to answer questions. Conclusions are dependent upon the questions asked, the perfection of the instruments, the techniques for securing the data, and the conditions under which the data are collected and analyzed. The research process may lead to conclusions that are simple and limited to highly specific situations, on the one hand, or which may be highly complicated and lead to sweeping conclusions, on the other. Creativity and expert knowledge in a specialized field are required of the investigator who is to make an addition to knowledge and practice.

If we accept as research any orderly treatment of the data of observations we include within it descriptions of the nature of things. Where and how people live, what they do, how they earn a living, what they believe, and what illnesses and complaints they have are examples in the human field of simple, basic, operations that may be described. Accurate observations and descriptions of natural events are the beginnings of scientific study. The records and reports of the trained person are commonly better than those of the untrained person.

We encounter another type of research in hospitals, institutions, schools, and government which is sometimes called "housekeeping" research. This is often a simple matter of counting, tabulating, surveying, and describing what we do. Such research often assists us in getting a better grasp of the dimensions of our job, what the costs are, and an appreciation of the extent of a problem or a need.

As soon as one starts sorting the data so as to see how they go together, he is engaging in a process called relational research. At its simplest level this may consist, for example, in tabulating accidents or diseases according to age or sex. Tabulations of the incidence of mental retardation by rural or urban residence, by occupational groups, by education of parents, by income levels, and by diseases of the mother during pregnancy would be examples of the routine analysis of relationships. Statistical techniques are available for studying relationships in a more precise and quantitative fashion. The coefficient of correlation is one of the simpler devices for expressing the association between variables. A coefficient of 1.00 indicates a perfect relationship between the factors being studied and a coefficient of 0 indicates complete absence of relationship. A positive or a minus sign indicates a direct or inverse relationship. Much work of this type has been done. Thus we find a coefficient of .50

Presented at the Annual Conference of the Michigan Association for Retarded Children, Central Michigan College, Mt. Pleasant, September 5-7, 1957.

*Herbert S. Conrad. Projects Under the Cooperative Educational Research Act (Public Law 531) Higher Education, 13:166-170, May, 1957.

between tested intelligence and ability to read, a coefficient of .70 between height and weight, a small coefficient such as .20 between height and intelligence. Small relationships mean that many other factors are involved. Appropriate techniques are also available to determine the contribution of each factor to the total variation encountered in a measured characteristic. A coefficient indicates association but usually cannot be interpreted as causation.

Many persons identify research primarily with controlled experimentation. Perhaps the largest experiment of all time was conducted recently when experimental and control groups were set up and records then kept for the subsequent incidence of poliomyelitis to determine the effectiveness of the Salk vaccine. Children in the experimental group received the vaccine and those in the control group a placebo. At times such experiments are the only final answer. The conditions for an adequate experimental design will be described subsequently.

Perhaps the most complex result of the research process consists in the construction of theory. The development of theory is designed to give greater mastery of a field. With adequate theory research can take on a more planned character and not be as dependent on random "cut and try" testing. The evolution of theory involves the identification of concepts or propositions, the derivation of hypotheses from these, the testing of hypotheses, the making of predictions of what is probably true, and the verification of these predictions.

At times a distinction is made between pure and applied research. So-called pure research is designed to secure knowledge for its own sake, to know more, to know with precision, and to develop a body of scientific theory. Applied research combines findings from many sources, correlates them with experience and wisdom, and plans a course of action. The goal is to produce change or movement in complex situations. The criteria for the success of applied research may be production, utility, economy, comfort, and satisfaction.

Research begins with the formulation of the problem. For example, one might ask the question, "Do mentally retarded children develop better in segregated classes or in regular classes in the public schools?" The experimental factor would be the contrast in the school experience. In order to get a sure answer to the question, the investigator would need to state the precise types of development in which he was interested and describe carefully the criteria for measuring change over a period of time. It would also be necessary to have comparable children in regular classes and in segregated classes. These should be sufficient in number so that reliable statistical conclusions may be drawn. In such comparisons it might also be possible to carry a comparable institutional group or a group of children who remain in their own homes. The possible sources of error are numerous in the establishment of experimental and control groups. The experimental factors are at times difficult to specify in terms that will permit the replication of the study. Repetition and verification under the same and varied conditions are a necessity in research.

For most types of conclusions with human beings it is necessary to have a control group since practically everything changes with time without the application of an experimental factor.

A simple experimental design would be as follows:

Experimental group: Initial Test — experimental factor—End Test—time lapse—Final Test

Control group: Initial Test—time lapse—End Test —time lapse—Final Test

A great many unjustified research and practical claims have been made because of failure to know what would happen in an equivalent control group without treatment. For example, the effectiveness of glutamic acid in mental deficiency was first studied without control groups and resulted in claims that could not be supported when control groups became a part of the design. Here a complication was not only the time factor but also a statistical problem known as the "regression" effect. In this, a group selected on one test tends to regress toward the mean on a second test whenever the correlation is less than 1.00. Thus high testing children tend to test less well and low testing children to test better on a second measurement. In the educational field this same type of unjustified claim often comes about in studies of remedial reading where a great improvement may appear in the treatment period. Such changes may occur in a control group of children without the treatment. The difference, even if real, may not persist over a period of

time after the remediation is stopped. Thus a follow-up after a time lapse is commonly advocated in human study. Important growth theory is involved. Phonics has recently come in for advocacy as a cure for poor readers because the persons who make the claims are not sophisticated in research design or in the explanations of individual differences among children.

There are many research designs of a less rigorous experimental character which, by statistical and other means, lead to conclusions of quite sweeping importance. For example, it is interesting and worthwhile to know that children become more and more unlike on most measurements as they grow older. It is valuable to know as we have found in our developmental studies that there are children who surprise us by a future status that could not have been predicted from their early history. It is interesting and valuable to know that children seek experience and nurture according to their stage of readiness and their needs. Nature and the environment have performed many experiments. It is possible to make some evaluations of the effects of deprivation by contrasting individuals and societies with and without schools, with and without medical services, with and without adequate diets, et cetera.

While research is often pictured as a cold, scientific, and orderly process it should be pointed out that it is also related to the values and value systems of a society or of a period in time. Thus, what investigators work on may be determined by the availability of financial support, by whether we have a threat of war or a promise of peace, and whether there are opportunities for large economic or other rewards in the event of success. An investigator eager to extend the boundaries of the known is usually at the core of every important problem.

Societies that limit education to a small and select group find different problems for investigation than a society which is dedicated to maximizing the potential of all members. The concern for the individual in American culture leads to a search for means for the improvement of the development of all.

There is much need for the communication of the findings of research and the practical implications for practice. This is accomplished by scientific publications, lectures, and through mass media. Investigators must communicate among themselves in order to share and advance in findings and theories. The practitioners must be in close touch with the investigators in order to move soundly. The policy makers on boards and in legislative halls must know the dimensions of the problem and the nature of the solutions. The general public needs to move from apathy and misinformation to concern and informed support. Thus there is a need for interpreters to relevant publics at both the scientific and practical levels. The process of information and communication is in itself susceptible to research study.

Summary

Research is seen to consist in the orderly treatment of basic observations and data through an expanding degree of complexity and generality leading to descriptions, relations, experiments, development of theory, predictions, application, and communication.

OBSTETRIC HEMORRHAGE

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grams of commercially available human fibrinogen will promptly raise the fibrinogen level and reestablish effective coagulation.

Unfortunately, the general use of human fibrinogen must be deprecated because of the possible presence of the virus of infectious hepatitis. Satisfactory methods of sterilization have not been discovered, as yet, and delayed deaths from induced hepatic necrosis have been reported. For the present, the use of human fibrinogen should be reserved for highly dangerous hemorrhage resulting from critical fibrinogen depression. Should it have been necessary to administer fibrinogen, the injection of gamma globulin in high dosage every five weeks for a period of six months has been suggested as prophylaxis to hepatitis.

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The Effect of Sympathectomy on Muscle Circulation

A *Fluorescein Study*

By Manuel Fernandez, M.D.
Detroit, Michigan

THERE IS still no general agreement as to the effect of the release of vasoconstrictor impulses on the normal circulation of skeletal muscle. The results have been contradictory both in man and in the experimental animal. On the other hand, all agree on the effect of sympathectomy in the circulation of the skin of humans and lower animals. It is said that the main function of the skin vessels is the regulation of body temperature, while in the muscles the vessels are essential for supplying blood to meet the energy requirements of activity.[19] This functional difference would make sympathectomy of little value to some, since the local metabolites are responsible for vasodilatation during exercise, and, to support this, it has been shown that the post-exercise hyperemia of normal muscle is not affected by previous sympathectomy.[8] The settlement of this problem has more than academic interest since its application in clinical medicine is of paramount importance in several pathological states. In arterial occlusive diseases, the value of sympathectomy on the muscle circulation is seriously questioned by many authors,[19,5,20] and favored by others.[8,18] In acute arterial occlusions, this form of therapy is also a matter of controversy in regard to limb and patient survival.[9]

The question of collateral circulation becomes, then, a primary objective in these investigations: are the collateral vessels under the control of vasomotor fibres, or is time the major factor in their development? Here again, there are those who deny sympathectomy any effect on the rate of blood flow or the size of the collateral vessels after the occlusion of the main trunk[9,2,8] and those who demonstrate an improvement after sympathectomy.[2,4]

The study of sympathectomy in these pathological states should be preceded by and based on its effects on the normal muscle circulation of both the experimental animal and the human being. Such work has been done by many, but again with different results. Grant,[13] Kunkel and Stead,[15] Freeman and Montgomery,[10] and Gage and Ochsner[12] have reported favorable results of sympathectomy on muscle blood flow, while Abramson and Ferris,[1] Freidlander et al,[11] and Stein et al[20] found no improvement. Elkin and Cooper[5] even found a diminution of blood flow after this procedure.

Many methods have been used in the past to study this problem: muscle temperature,[17] femoral artery pressures,[21] plethysmography,[1] radioactive Na,[5] arteriograms,[3] micrometric studies,[9] and electrical stimulation.[6] The purpose of this study is to demonstrate by means of fluorescein injections the effect of sympathectomy on the blood flow of the normal gastrocnemious muscles of the dog.

Method

The gastrocnemious muscles of anesthetized dogs were skinned and dissected bilaterally from their insertion at the Achilles tendon to their origin in the leg. These group muscles are easily separated from the other muscles of the leg without severing any of their supplying arterial trunks, since these arise from the distal caudal femoral artery, a branch of the superficial femoral given off just above the popliteal space.[16] Thus this cephalad dissection leaves these arteries intact. The lumbar sympathectomy was always done in the left side and four or five ganglia from the intervening chain were removed. This operation was completed 30 to 60 minutes before the injection of the fluorescein. Fluorescite† 10 cc. was injected directly into the abdominal aorta as rapidly as possible, and directed caudally. Both gastrocnemious muscles were placed under a portable 100-watt ultraviolet lamp. The amount of fluorescein visualized within three to five minutes after its administration served to determine the amount of muscle-blood

From the Highland Park General Hospital, Department of Surgery, Detroit, Michigan.
Presented before the Michigan Chapter of the American College of Surgeons, Ann Arbor, March 12, 1957.

†Fluorescein 5 per cent with Sodium Bicarbonate. C. F. Kirk Co., N. Y.

flow and the effect of unilateral sympathectomy. Intraperitoneal nembutal anesthesia was used, and attempts were made to maintain all animals in light anesthesia throughout the studies. This would tend to avoid the so-called "chemical sympathectomy" of the unoperated side.[9]

Results

Fifteen dogs were used. The dissection of the gastrocnemious muscles was carried out with minimal blood loss and preservation of the venous circulation of the skin flap. Care was taken to keep the field clean and to mobilize the muscles sufficiently to bring them together and parallel to each other for closer and more accurate observation and comparison.

Five controlled studies were made in which the fluorescein was injected in the normal animal and its distribution studied. The patterns of distribution on the muscles in question were almost identical in both gastrocnemious, and consistent in all animals. The fluorescence is first seen at their origin and slowly spreads distally in all of the belly, reaching into the tendinous portion. At the end of five minutes, maximal fluorescence is attained. Ten unilaterally sympathectomized dogs were done. In all of these dogs, the sympathectomized side demonstrated an increase in the amount of fluorescence as compared with the normal side. This increase was well maintained throughout the period of observation. It is important to point out here that the fluorescein made its appearance simultaneously in both muscles, whereas the penetration and extent of its distribution was considerably better in the sympathectomized side.

Discussion

Almost all the blood flow studies in the literature are total blood flow studies.[8] This, of course, holds true mostly for the human subject where plethysmography has been widely used.[20] In the experimental animal most of the work on muscle circulation has been done on the effect of sympathectomy on the collateral circulation after previous ligation of the main arterial trunk,[17] and on the effect on the collateral circulation after the establishment of an arteriovenous fistula.[4]

In our experiments, the arterial supply to the gastrocnemious muscles is derived almost exclusively from the distal caudal femoral artery, a collateral of the superficial femoral. Preliminary studies in our laboratory demonstrated that ligation of the deep femoral and of the proximal caudal femoral artery alone did not diminish appreciably the blood flow to the gastrocnemious, while ligation of the superficial femoral just proximal to the origin of the distal caudal femoral artery resulted in almost complete ischemia to these muscles.[7]

It is a well-established fact that sympathectomy has its maximal effect at the arteriole where peripheral resistance is upheld by vasomotor impulses. That the main arterial trunks are not significantly dilated by vasoconstrictor release has been shown before.[14] These principles when applied to our results would support the following conclusions: First, that the superficial femoral artery in the sympathectomized side was not affected significantly by this surgical procedure nor was the rate of blood flow, since the fluorescein reached the gastrocnemious muscles at the same time in both the normal and sympathectomized side. Second, that the muscle blood flow was increased in the sympathectomized side due to a lowered peripheral resistance at the arteriole level.

Within the limitations of our experimental method, it is apparent that sympathectomy increases the blood flow in the normal skeletal muscle of the dog.

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Atropine Coma Therapy: Report of a Death

By Gordon R. Forrer, M.D.
Northville, Michigan

REPORTS of deaths due to atropine toxicity have rarely appeared in medical literature. There is a widespread belief that atropine is a "dangerous" drug. The literature (and our own experience in the use of atropine sulfate in exceedingly large amounts) suggests that the drug is relatively non-lethal. As much as 15 grains, or 1,000 mg., has been injected with recovery.[1] For the most part, reports in the literature on the toxic properties of atropine sulfate emphasize febrile response, glaucoma, and the delirifacient properties of the drug. The following case is thought to be of especial interest, since a measured amount of atropine was administered with therapeutic intent.

Atropine coma therapy has been administered to somewhat over 900 mentally ill patients to date. The treatment is administered four times a week. Atropine sulfate is given by intramuscular injection, beginning with 32 mg., and increasing the dosage as high as 212 mg. This size dosage contrasts dramatically with the conventional 0.5 mg. of atropine given by mouth. The ensuing coma can be compared with insulin coma, produced for similar therapeutic indications. Atropine detoxification is spontaneous, and is usually complete between six and eight hours after injection. This case is the only known death to have occurred to date with atropine coma therapy.

Case Report

History.—C. V., a fifty-three-year-old white man, was admitted to the Ypsilanti State Hospital on October 27, 1949. He had worked as an attendant for five years prior to admission. There was information to suggest that he had been delusional, but still capable of working adequately during this entire period of time. There was a long history of alcoholism and "peculiar behavior." At the time of his admission there were clinical findings suggestive of a schizo-affective reaction with manic trends. He would sing and talk to himself, had grandiose ideas in regard to money and his sexual prowess, and was delusional—believing that his employer had broadcast over the radio that he, the patient, was to be appointed Secretary of State. He accused his wife of plotting with the neighbors to have him shot so that she could be unfaithful to him. He insisted that the lights on automobiles were signals intended to convey messages about himself and he expressed the intention of getting a gun and killing his persecutors. He related to his wife that he had killed people, and told her that he should have killed her, too. He stated that he had exonerated himself from these actions by "wearing a brown suit." He bragged that he had been discharged from the navy as a rear admiral.

On admission to the hospital he stated that all of his trouble was because of his wife. He felt that he was railroaded into the hospital and insisted that his wife was unfaithful to him, convincing evidence to the contrary, notwithstanding. There was considerable elevation in mood. He was well oriented in all three spheres, but his insight as to illness was absent. He stated, "I am an employe. I'm not a patient. There is nothing wrong with my mind. I'm not crazy. I'm not a bug. I'm a thirty-third degree Mason." There was flight of ideas, circumstantiality, and a moderate degree of agitation.

Physical examination was not remarkable. All laboratory examinations were normal. Blood pressure was 142/82; pulse was 74. There were no murmurs on auscultation. After an adequate period of observation, without any change in his mental condition being observed, it was felt by the medical staff that he would benefit by receiving atropine coma therapy. Accordingly, he was administered 32 mg. of atropine sulfate by intramuscular injection. During the first hour the patient's blood pressure rose to 150/90 and at the third hour had dropped to 130/60. At the sixth hour the blood pressure was 120/50, and at the eighth hour the blood pressure was 120/50. His pulse rate varied between 130 and 120 until the eighth hour, at which time it was 100. Respirations, which were 20 before the initiation of therapy, rose to 30 and remained at this level until the seventh hour, at which time they were again 20. The skin was flushed throughout the period of the atropine effect. He was somewhat restless from the second hour on, but this is not remarkable and is commonly found in patients receiving this type of treatment, especially during the first treatment. There was no excitement noticed, and after the second hour he slept continuously with some outbursts of restlessness. Alcohol sponges were given in the third hour because of a rise of temperature to touch. When the temperature became normal, these were discontinued. During the entire course of treatment the patient was considered to be reacting in the usual manner. No anxiety was felt for his condition. Pulse, respiration, and blood pressure, as noted above, were not particularly remarkable.

Because of a tragic break in nursing technique the patient's temperature was not checked after it had re-

turned to normal following the alcohol sponges, and it was not until the ninth hour that it was observed that he was hyperpyrexic and not responding like the other patients. The room temperature at this time was well above normal and two other patients receiving therapy that day also developed temperature elevations. Respiration ceased at 5:00 p.m., nine hours after the administration of the drug, despite intracardiac adrenalin and liberal ice-water sponges. Temperature at the time of death was beyond the limit of the clinical thermometer. All efforts at resuscitation failed. The other hyperpyrexic patients responded satisfactorily to alcohol sponges. The temperature of one rose to 106 degrees and the other to 107 degrees. It was felt by the physician that the cause of death was hyperpyrexia and respiratory failure due to atropine toxicity. A complete autopsy report follows.

Autopsy Findings.—(Gross report): The body was that of a short, well nourished individual of pyknic build, in whom rigor mortis was present. There was marked cyanosis of the upper part of the chest, neck and head with some evidence of bleeding about the nose and mouth. There were no marks of external violence and no evidence of external gross deformity.

(Internal Examination) The skull: There were no abnormalities of the scalp, skull or dura, and the brain grossly appeared normal except for some evidence of atrophy in the occipital lobes. The vessels at the base were somewhat thickened, but there was no prominent atherosclerosis. Cut sections of the brain revealed hyperemia and edema, particularly marked in the cerebellum, in the white matter around the basal ganglia, and in the midbrain. No areas of focal pathology were seen.

The Thorax: The organs of the thorax were found in their normal position. The lungs were boggy, edematous, and on cut section exuded a dark, bloodstained fluid. Sections of the lungs floated in water, and there was no evidence of consolidation or focal pathology. Mediastinal lymph nodes were somewhat swollen, but otherwise normal. The heart showed marked thinning of the right ventricle, and to some extent, the left ventricle. Coronary circulation appeared to be patent, although there were early sclerotic changes seen in the coronary vessels. In the aorta there was a plaque measuring about 1.5 cm. in diameter over the ostia of the left coronary artery, and several other early atherosclerotic plaques. Small yellowish infiltrations were seen also in the endothelial lining of the ventricles, and there was some congestion of the valves.

The Abdomen: The panniculus was thick, but the abdominal organs were all found in their normal positions. The liver was pale, large, and there were several areas of yellowish tissue penetrating the surface to a distance of about 3 or 4 cm. over the anterior surface of the liver. In addition, there was a nutmeg appearance, but no focal pathology. The spleen was somewhat large, soft and mushy, but showed no focal pathology. The kidneys showed chronic passive congestion with increased marking of the cortex and considerable increase in the amount of fat, but no focal pathology. The stomach was hyperemic and contained many undigested raisins, but otherwise was not remarkable. No abnormalities were seen in the genitourinary tract or gastrointestinal tract, and the adrenal glands appeared to have undergone postmortem autolysis.

From the gross findings the cause of death was not determined.

Histologic Report.—Sections of the brain (stained by the hematoxylin-eosin method) showed, to a remarkable degree, the multiplication of large bacteria in the vessels of the liver, kidneys and lungs. While it is possible that these could represent overwhelming bacteremia antemortem, lack of any reaction around the organism, their large size, and their limitation to the blood vessels, themselves, suggested a postmortem growth. Unfortunately, the presence of these organisms with the consequent autolysis of tissues made the reading of the slides remarkably unreliable. Certain findings, however, were valid. These consisted of a large atherosclerotic plaque in the aorta described grossly, remarkable thickening of the media in the vessels of the kidney, with concomitant cloudy swelling or autolysis, while the liver showed fatty infiltration (to some degree), as well as autolysis. The lungs showed recent and old hemorrhage, together with considerable lymphocytic exudate, which, however, had reached the state of consolidation. Changes in the brain were most marked in the region of the hypothalamus, where fairly advanced calcification was seen in the walls of practically all of the vessels. In addition to this, there were early degenerative changes in many of the neurones, some of them being pigmented and vacuolated, and there was an apparent decrease in the total number. A large colloid cyst was seen in the pituitary. The adrenals also showed vacuolization of the cortical layer.

All of these findings must be interpreted with extreme caution, in view of the postmortem contamination of the body. The lung hemorrhages, normally a possible cause of death, can be discounted if much artificial respiration was used either before or after death. The degree of atherosclerosis present was impressive, but may have been only a contributing factor. No specific evidence of atropine poisoning was seen.

Discussion

This death occurred very early in the investigation of atropine as a coma-producing drug in the treatment of psychotic reactions. A great deal has been learned since that time, and as a result of modification of technique, such hyperthemias as reported in this paper no longer occur. A combination of decrease in sweating and hyperactivity is closely related to hyperpyrexia due to atropine. We have found sodium amytal (grains 3¾) administered intramuscularly to be most effective in controlling the hyperactivity and consequently, the pyrexia. The room temperature also has an obvious relationship to a pyrexic re-

sponse. Since we have installed a dehumidifying unit, pyrexic responses are unusual. In our experience, immediate and active measures with ice-water sponges have always been effective, and the temperature promptly returns to normal. We no longer use alcohol for sponging purposes, since the inhalation of the fumes tends to be a depressant. Since the detoxification of atropine takes place in the liver, it is our opinion that atropine coma therapy should be used with caution in patients having evidence of liver damage.

Summary

Death due to the administration of 32 mg. of atropine sulfate is reported. Because of bacterial contamination, no definite statements can be made regarding the pathologic picture of atropine poisoning. The degree of atherosclerosis present in this patient was impressive, and may have been a contributing factor. An allergic response to the drug should be considered as a possibility, but other allergic responses have never been observed in atropine coma therapy to date. Improvements and modifications in techniques have made possible the administration of massive doses of atropine sulfate with a degree of safety which exceeds that when insulin is used as the coma-producing agent. The death reported herein, after careful evaluation, seems to have been due to a set of circumstances each one of which played a role: high room temperature and humidity, impaired detoxification of the drug due to liver damage, failure to maintain normal temperature through alcohol sponges or ice-water sponges, and a break in nursing technique.

Addendum

Results of research, determined after the submission of this paper for publication, demonstrate that atropine coma may be completely terminated at any time after its onset by the administration of 4.0 mg. physostigmine intramuscularly. Details will be published in a forthcoming paper.

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41001 Seven Mile Road

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Routine Endotracheal Anesthesia for Tonsillectomy and Adenoidectomy

By Jordan C. Ringenberg, M.D.
Edward C. Thompson, M.D.
Grand Rapids, Michigan

ENDOTRACHEAL anesthesia for adults undergoing tonsillectomy has been an accepted procedure for several years. Its routine use in children has been encouraged in some of the larger medical centers, but the majority of tonsillectomies and adenoidectomies are performed without the benefit of endotracheal anesthesia.

Opposition to the use of endotracheal anesthesia on the part of the surgeon has largely been based on a fear of trauma to the larynx of the child, with the possible development of edema necessitating tracheotomy, or the late development of laryngeal granulomas from contact irritation from the endotracheal tube. Many surgeons also are opposed to the use of an endotracheal tube, as they feel it interferes with their technical manipulations during the tonsillectomy.

Anesthesia for tonsillectomy without the use of the endotracheal tube may be hazardous. The danger of respiratory obstruction, anoxia and cerebral damage, or cardiac arrest and death is always present. It is not uncommon to see degrees of respiratory obstruction and cyanosis during tonsillectomy using the "ether hook," which would not be tolerated during any other form of modern anesthesia and surgery. The respiratory obstruction is due to the presence in the child's pharynx of a thick tongue, blood, mucus, surgical instruments, and constant suction tending to lighten the anesthesia and leading to reflex laryngospasm. To give effective artificial respiration or to assist the child's respiratory excursion while this chain of events is going on is impossible. The anesthesiologist can only insufflate oxygen into the open mouth and be prepared to establish an effective airway by means of an endotracheal tube if the situation becomes more critical.

With the elective use of an endotracheal tube its advantages become apparent at once. Hasty surgery is no longer necessary because of the deteriorating condition of the patient. In its place there is calm careful surgery with adequate and sure hemostasis. The patient's airway and oxygenation are assured, and, if necessary, controlled respiration can easily be carried out. An even depth of anesthesia in light planes is easily maintained, and the suction may be used at will without fear of lightening the anesthesia. Exposure for the operator is improved because now the tongue may be retracted as necessary without fear of producing respiratory obstruction.

Endotracheal anesthesia has been used routinely for tonsillectomy and adenoidectomy at St. Mary's Hospital, Grand Rapids, Michigan, during 1956 and 1957. A total of 1,151 cases have been done using this method of anesthesia. Their age range is as follows:

Age	*Number of Cases*
2	42
3	124
4	217
5	251
6	175
7	120
8	78
9	64
10	36
11	26
12	18
Total	1,151

Our technique emphasizes the following points:

1. Preoperative medication includes both morphine and scopolamine. The morphine is given in very small doses to help allay apprehension, while relatively large doses of scopolamine are given to decrease mucus production to a minimum.

2. Induction of anesthesia is by open drop with Vinamar, with gradual addition of ether until surgical anesthesia, upper plane III is reached.

3. Intubation is done by direct laryngoscopy with the patient sufficiently deep in anesthesia to obtund the laryngeal reflex. Gentleness during the exposure of the glottis is stressed. Endotracheal tubes are of the thin-wall Portex type. If any resistance is encountered to insertion of the tube the next smaller size is chosen at once. The tube

is advanced into the trachea for approximately one inch. The tubes are cut short to prevent further advance than this, and to minimize the possibility of entering the right main bronchus.

4. Maintenance of anesthesia is by ether oxy-

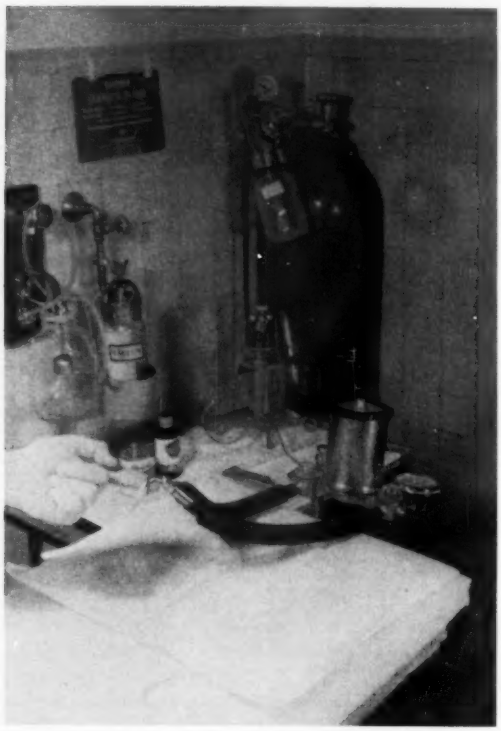

Fig. 1. Anesthetic equipment for maintenance of ether-oxygen endotracheal anesthesia for tonsillectomy.

gen, using a carbon-dioxide absorption, circle breathing machine especially designed for pediatric use (Fig. 1).

5. The entire operation is done in 10° Trendelenberg position to prevent aspiration of blood and mucus around the tube.

6. At the termination of the operation the child is placed on his side still in Trendelenberg position, and intermittent gentle suction applied to the tube during withdrawal.

7. If there is any evidence of persistant laryngospasm following extubation oxygen is given by mask or catheter.

8. Following surgery, patients are removed to the recovery room where they receive oxygen by oral insufflation until they have reacted fully. Recovery room carts are in 10° Trendelenberg position during this period.

There have been no serious complications in this series of 1,151 cases, and only four instances of hoarseness, all of which cleared within twelve hours. Tracheitis and bronchitis have not been seen, nor has laryngeal edema necessitating tracheotomy.

Laryngeal granuloma has not been found in these cases during the post-operative period.

Summary

The inherent dangers of respiratory obstruction during tonsillectomy has been emphasized. The advantages of endotracheal anesthesia during this procedure have been presented. A group of 1,151 consecutive tonsillectomies under endotracheal anesthesia without serious complications or late sequelae is reported.*

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522 Medical Arts Bldg.
Grand Rapids 2

*Since this article was written 800 additional operations have been performed without laryngeal complications.

Lay Medicine during the Early Middle Ages

By Benjamin Lee Gordon, M.D.
Ventnor, N. J.

APART FROM a small number of Byzantine lay physicians, few lay doctors are mentioned in the history of the early Middle Ages. That such physicians existed can be inferred from the famous schools that existed during the fourth and fifth centuries in the East at Alexandria, Constantinople, Berytus, Caesarea, Laodicea, Pergamos, Antioch, and Athens, and in the West at Rome (Athenaeum), Ravenna, Marseilles, Autun, Bordeaux, Treves, Toulouse, Poitiers, Lyons, Narbonne, Arles, Vienna, and Besancon. These schools were mostly under direction of pagan teachers, and their curriculum included philosophy, medicine, law, literature, grammar, and astrology.

The physicians of pagan origin who were educated in these schools could not have suddenly passed off the face of the earth and turned their profession abruptly into the hands of the monks. As a matter of fact, Italy at no time entirely lacked lay practitioners of good repute who gave private instructions to students in medicine. It is related that, in the second half of the sixth century, Alexander of Tralles practiced in Rome and, as it was the practice in those days for physicians to train aspirants for the profession, he most likely taught the art of medicine to disciples there. It is further reported that Pope Gregory invited the Archbishop of Ravenna, Marianus, to Rome in order to undergo medical treatment for a malady of the chest. This further bears out the supposition that, in the midst of the ruins of the past, glowing embers of the old Greek tradition never became completely extinguished, but continued to glow under the ashes and were from time to time—even with Church opposition—fanned into fresh flame.

As has been intimated, it would be a mistake to conclude that the preponderance of clericism and monasticism brought about the complete disappearance of the lay practitioner. A survey of the entire period emphasizes the fact that the decay of medicine, and culture in general, did not keep pace with the decline of Roman dominion. Rome continued her individual existence and many schools of learning kept their doors open although their brilliance faded. In the East, we read of the Nestorians of the Bactishua family, of the School of Translators and of others.

In Italy, there were some lay schools kept open in defiance of the Church. These schools were attended not simply by youths desiring to obtain an education, but also by grown men. The subjects taught were grammar, rhetoric, philosophy, jurisprudence, and medicine. The teachers were appointed by the municipal council and enjoyed certain privileges, such as, exemption from the duty of quartering soldiers and from other public burdens. Many students went to Italy for their general education, and some went to Constantinople, the capital of the Eastern Empire, where a few secular schools were still in existence. Generally speaking, physicians of pagan origin who practiced medicine outside of the Church were not respected, as their background was poor and their training only superficial. They had no formal school education.

Lay physicians were largely employed to give expert testimony in legal matters dealing with gynecology, such as, when the virginity of a litigant had to be established. Such cases, naturally, could not be openly handled by the clergy. Expert testimony, in cases of bodily injury and poisoning, also was given by lay physicians.

There existed hospitals under lay administration at Lyons in 542, and at Merida in 580. Besides the hospital physician, there was also the physician-in-ordinary with the title of "Archiater" who performed definite functions. Lay physicians were employed as personal physicians at the palaces of the rulers and even to care for the Popes.

Under Theodoric the Great (454-526), Italy, which in the fifth century had undergone such severe trials, passed through a period of peace and enjoyed material prosperity. The most jealous consideration was given for Roman tradition in the administration of government and the promotion of art and science. In the latter respect, it suffices to mention the names of Cassiodorus,

Boethius and Ennodius (474-521). Theodoric, one of the noblest rulers who ever held sway over Italy, wished to be a protector of the Romans rather than a conqueror, and it is for this reason that he left them in possession of their laws and institutions. He established liberal laws and institutions for both the Romans and the Goths, and these people lived in proximity following their respective native customs without any marked antagonism.

Theodoric was the first king in Europe to recognize different nations living within their own clearly-marked boundaries as equals. He was not only a patron of the arts and sciences but it is known that his own talented daughter, Amalaswintha, spoke Greek with the Greeks and Latin with the Romans. She saw to it that her son, Atalaric, was instructed in the Roman arts. The Goths possessed a comparatively high development of language, and many of them evinced inclination toward scientific studies.

King Theodoric formulated wise regulations governing the practice of physicians (*archiatri*). His concern for medicine and his noble advice to the *archiatri* are well expressed in the famous "Eulogy and Counsel of Theodoric":

The Eulogy and Counsel of Theodoric

Among the most useful arts that contribute to sustain frail humanity, none may be regarded as superior—or even equal—to medicine, which aids the sick with its maternal benevolence, puts our pains to flight, and gives us that which riches and honour are unable to give. . . . Leave aside, O men of the medical arts, those controversies that are prejudicial to the sick; and if you are not able to come to an agreement consult someone whom you can question without dislike, for every wise man is willing to seek counsel and he is regarded as the most zealous whose frequent questions prove that he is most wise. At the very beginning of your career in this art you are consecrated by oaths like those of the priests: you promise solemnly to your instructors to hate iniquity and love honesty. . . . Remember that to sin against the health of a person constitutes homicide. When I honour you with the title of *Comes Archiatrorum* so that you will be esteemed among the masters of the art of healing and everyone will ask your opinion, I warn you to demonstrate that you are a just arbiter in this notable art. . . . To the expert archiater may the pulse reveal our internal disorders, may the urine reveal them to his eyes. Enter freely into our palace, with full confidence, and may it be permitted to you to prescribe diets, to say things that one would not dare to hear said, and to prescribe even painful treatment in the interest of our health.[1]

The era of the Ostrogoths has bequeathed to us at least one work possessing a trace of originality—"The Dietetics of Anthimus." Anthimus (5th century) was a Greek physician and the last lay author who flourished before medicine passed over into the hands of the clergy. Anthimus was expelled from Byzantium and he journeyed to Italy with Theodoric the Great where he lived for a while as an emissary of the Ostrogoths to the court of the Frankish King Theodoric. His work on dietetics is mainly based on ancient works although he includes his personal experience as a practitioner among the Goths. It is written in the form of an epistle.

He asserts in the introduction that rational dietetics is the foundation of health and the primary factor in preventing disease. He advises moderation in eating and drinking and states that personal preparation of food should not be neglected even on journeys. He states that food should be easily digestible.

Anthimus lists one hundred different articles of food and drink which are digestible and nourishing and discusses the preparation of each. He points out the nutritional value of each of the individual parts of the ox and swine. He warns against the use of pickled meat, bacon-rind and pigeons, "because they feed on helebore," and he also cautions against the use of hard boiled eggs, old cheese, most mushrooms, old fish and oysters.

Anthimus, oddly enough, believes in the therapeutic efficacy of bacon in treating intestinal parasites and of partridge flesh and rice cooked in goat's milk in combating dysentery. He employs barley-meal porridge diluted with tepid water in treating fever and almond or fig emulsion in cases of catarrh and angina.[2]

Other lay physicians were the *archiater* Peter, who was court physician to a later Frankish king named Theodoric (about 605), and the *archiater* Reovalis (about 590). The latter mentions that he was called in to see a small boy who had a disease of his thigh; the little patient's case had been given up as hopeless. He writes: "I, having made an incision into the testicles [strangulated inguinal hernia?], as I had once seen done in the city of Constantinople, restored the boy sound to his sorrowing mother." This narrative indicates the existence at this time of a higher class of lay physician who possessed some surgical knowledge and skill. This was doubly important at a time when surgery was forbidden to monkish physicians.

Among the Alemanni,† lay physicians were employed for medico-legal duties. In the Germanic codes, mention is made of the fee to be granted the physician in the determination of the penalty for bodily injuries. The Langobard Code, promulgated in the year 650, contains this stipulalation: "Whosoever has inflicted wounds upon anyone, he shall supply him with attendance and likewise pay the fee of the physicians, at a rate to be estimated by learned men."

Among the Visigoths, the lay physician, having undertaken the treatment of a case, was obliged to conclude an agreement concerning proper remuneration and also to post security for malpractice. For the cure of various diseases there were distinct fees; for example, a fee of 5 *solidi* was charged for a cataract extraction. If the patient died but the physician had performed his duties satisfactorily, the physician received no fee but he could withdraw without hindrance. If the physician committed any technical error, he had to pay a fine. If, however, the death of the patient was brought about by the treatment of the physician, the physician was subject to fine or worse. If the patient were a servant, the physician had to provide another servant of similar value; if, on the other hand, he were a freeman, the physician laid himself open to arbitrary punishment from the relatives. The physician could only perform venesection on free women in the presence of a relative—even if the procedure were deemed urgent. Any infraction of this regulation led to a fine of 10 *solidi*.

Such stringent enactments naturally hindered medical action—particularly reputable medical action—for none but itinerant quacks could hope to escape criminal prosecution.

What ecclesiastic domination failed to accomplish in the process of disintegration of medical practice was completed in the sixth century by famine, by savage wars that raged between the Ostrogoths and the Byzantines, and, most of all, by the pestilences which followed in the wake of the wars. This terrible devastation which continued to the eighth century strangulated all pursuit of science and undermined all confidence in lay medicine. In the face of the epidemics, the lay physicians became helpless and the people abandoned themselves entirely to faith. To be sure, the clerical physicians could not avert an epidemic or cure those who were stricken by it, but their methods were harmless and appealed to the religious sense, and the patient at least was inspired by the hope of entering a new and brighter existence in the hereafter.

On the other hand, the lay physician at that period had nothing to inspire confidence. His chief methods of diagnosis were based on uroscopy and palpation of the various pulses, and even if he reached some conclusion as to the disease, his treatment was revolting and cruel and not devoid of superstition. To attempt to catalogue all remedies and cures that have passed the alimentary tract of man throughout the ages is to undertake to compile a work of human folly. In the name of the healing art man has resorted to wild nostrums, loathsome and nauseating excreta of cats, dogs, goats and even bats and mice, and disgusting remedies such as snakes, toads, lizards and mice.

Hanging the victim by the feet or gouging out one of his eyes so that the poison might run out were regarded as proper methods of curing poisoned patients. The last is said to afford the explanation as to how Emperor Albrecht lost one of his eyes. Even so eminent a naturalist as Conrad von Megenberg, as late as the year 1342, went from Vienna to Regensburg to the grave of St. Erhard for the sole purpose of creeping over his grave while a hymn of his own composition was sung.

The time of taking the various abominable mixtures prescribed by the physician was often determined by the position of the sun, moon and stars. At times the relative wealth of the patient guided the practitioner in compounding his prescription.

In addition to the lay doctors, there were old wives, eccentric individuals, shepherds, minstrels, jugglers, executitioners, and similar gentry who dabbled in medical practice.

Said Oliver Wendell Holmes (1809-1904): There is nothing men will not do; there is nothing they have not done to recover their health and save their lives. They have submitted to be half-drowned in water, and half-choked with gases, to be buried up to their chins in earth, to be scarred with hot irons like galley slaves, to be crimped with knives like codfish, to have needles thrust into their flesh, and bonfires kindled on their skins, to swallow all sorts of abominations, and to pay for all this, as if to be singed and scalded were a costly privilege, as if blistering were a blessing and leeches a luxury.

†The Alemanni were an ancient people of southwestern Germany.

In the seventh century, the embryonic lay-physician studied in the traditional manner under the tutelage of an older physician.

All physicians were subject to certain rules and regulations. The "Fuero Judzgo," a Spanish translation of the original code of the Visigoths entitled "Forum Judicium,"* reads as follows:

1. No physician may undertake to bleed a woman in the absence of her relatives; if he has done so, he shall pay 10 *solidi*** to the relatives or to the husband, since it is not impossible that occasionally some advantage may be associated with such an opportunity.

In all Germanic legal codes (Salic, Ripuarian, Bavarian) carnal offenses were very severely punished. Whoever touched the hand, arm or breast of a maiden was fined 15, 30 or 35 *solidi*, in the order mentioned. A manservant who impregnated a maid of another, who died during pregnancy or labor, was castrated. Hence, it follows that this unchristian operation was still in vogue and was performed as a punitive measure. Castration was likewise performed from motives of pure revenge, as the case of Abelard (who was castrated by the friends of Heloise in consequence of his love for her) proves. The same vengeance too was commonly taken among the southern Slavs, Arabs, Abyssinians, Negroes, Turks, and Indians.

2. No physician shall visit any person confined in prison without the presence of the jailer, lest the prisoner, through fear of his punishment, may seek the means of death at his hands.

3. When anyone has called a physician to see a sick person, or to heal a wound, the physician, when he has seen the wound or recognized the pains, shall at once take charge of the patient under definite security.

4. When a physician has assumed charge of a patient under security, he must cure him. If death ensues, he shall not demand the stipulated fee, nor shall a suit be instituted by either party.

Some physicians, however, in serious cases, guarded themselves from prosecution by having the patients declared legally dead in advance of treatment, so that if death actually ensued it could not be ascribed to their treatment.

5. If a physician has removed a cataract from the eye and restored the patient to his former health, he shall receive a fee of five *solidi*.

6. If a physician injures a nobleman in bleeding him, he shall pay 150 *solidi*. If, however, the patient dies, the physician [how equitable!] shall be delivered up at once to his relatives, to be dealt with as they may see fit. When, however, the physician has killed or injured a slave, he must return a slave of the same kind.

7. When a physician has accepted a student, he shall receive a fee of twelve *solidi*.

8. No one shall cast a physician into prison without a hearing, except in case of murder.[3]

It should be noted that there was a distinction made between a visit to the sick, and a visit for treating a wound. In Sweden† the educated physician was expected to understand not only illness, but also treatment of fractures, incised wounds, wounds of the skin, stabs through the body and amputations. The unerudite lay physician was regarded as a mere mechanic and tradesman.

It does not follow, however, from the ordinances cited, that the physicians of the Visigoths were necessarily regarded with special disrespect. These ordinances, like all similar laws from the beginning of time to the present day, were instituted chiefly to provide against transgressions and to meet exceptional cases.

In spite of the fact that lay physicians were considered members of the so-called lower class, their high remuneration and severe penalties indicate their relatively high social position.

Toward the midpoint of the Middle Ages, monkish or clerical medicine had about entirely superseded all higher lay practice, and for all practical purposes only herniotomists, lithotomists, oculists and lower medical itinerants survived. The position of the lay physician at this time, particularly, was considered disreputable as may be inferred from the action of King Gram, who, in order to remain unrecognized during a festival, put on the dress of a physician and took the lowest seat at the dining table.

The so-called *volksarzte* of the Germans were probably the uninterrupted successors of the lower itinerant physicians. The higher class lay physicians, who still existed among the Goths in the beginning of the Middle Ages, disappeared, or at least took a position of inferiority until the foundation of the school at Salerno and the European universities.

Anthimus (fifth century), to whom we have hitherto referred, is the last lay author of the West for a period of 400 years. Following him

*This translation was made by order of Ferdinand III, in 1241, and formed the basis of Spanish medieval law.

**Two *solidi* was the price of an ox. Hence this fee for a private venesection is very high.

†Laws of Sudermania; compiled 1327.

the conduct of literary affairs remained in the hands of the clergy and monks.

It is related that Cassidorus, "the last Roman," amidst the chaotic confusion erupting in the West, undertook the responsibility of preserving the heritage of literature through monkish influence, without, however, taking measures to combat the superstition which flourished so universally in his unenlightened era.

Cassiodorus recommended the study of medicine to the monks, giving them detailed advice as to which writers of antiquity should be studied as a foundation for learning the healing art. Addressing the monks, he declared:

> Learn to know the properties of herbs and the blending of drugs, but set all your hopes upon the Lord, who preserves life without end. If the language of the Greeks is unknown to you, you have the herb-book of Dioscorides, who has described and depicted the herbs of the field with astonishing accuracy. Afterwards read Hippocrates and Galen in Latin translation especially the Therapeutics of the latter, which he has dedicated to the philosopher Glaucon, and the work of an unknown author, which, as would appear from investigation, is compiled from several writers. Study further the Medicine of Aurelius Caelius, the Hippocratic book upon herbs and healing methods, as well as a variety of other treatises upon the healing art which I have brought together in my library and have bequeathed to you.

He stressed that the healing art was a worthy calling in that it concerns both the present and future well being of patients and aids them when other . . . spiritual . . . means fail. He warned physicians to avoid quarrels, jealousy, all forms of wickedness, and all methods of disreputable therapy. He exhorted physicians ever to seek knowledge, to read the works of the Ancients, to manifest zeal and cheerfulness in treating the sick, and to seek purity in their personal lives. For an effective bedside manner, the following advice was given:

> Let your visits bring healing to the sick, new strength to the weak, certain hope to the weary. Leave it to clumsy (practitioners) to ask the patients they are visiting whether the pain has ceased and if they have slept well. Let the patient ask you about his ailment and hear from you the truth about it. Use the surest possible informants. To a skillful physician palpation of the pulsing of the veins reveals the patient's ailment while the appearance of the urine indicates the prognosis. To make things easier, do not tell the clamoring inquirer what these symptoms signify.[4]

The seeds of Cassiodorus did not fall on barren soil. The works or translations recommended by him are still in part extant in numerous manuscripts.

One of the most liberal monarchs, Emperor Charlemagne (742-814), King of the Francs, was a patron of the classics. He organized schools at every cathedral modelled after the schools of the Egyptian temples and Arabian mosques, and from the year 806 onward, it was expected that medicine should be included in the curriculum. These institutions were important not only in the development of general education but also in the revitalization of medical knowledge. Such schools were developed in Paris, Fulda, Wurzburg, Herschaw, Metz, Lyons, Cremona, Para and Florence. The personal physicians of Charlemagne were Wintraw and a Jew named Abul Faradsh; the latter must not be confused with the Arabian historian of the same name who is also known as Bar-Hebraeus (1226-1286).

To the curriculum of the Cathedral Schools which originally embraced the seven sciences (the trivium: grammar, logic and rhetoric; plus the quadrivium: arithmetic, music, geometry and astronomy), he ordered that medicine should also be taught under the name of *physic*.

In England, King Alfred (849-901) is known not only as a warrier but also as a proponent of higher education. He is, without question, one of the greatest men England has ever produced. Under his sovereignty, good laws were enacted and his was a golden age of peace and happiness for his subjects. He always stood ready to improve the lot of his subjects. He founded schools for rich and poor in England. One of his schools was founded in the city of Oxford (*not* the famous university of the same name).

Like Charlemagne, Alfred, in his educational work, received assistance from monk scholars. He was also aided by the learned Jews who came to live at his court by invitation. He divided his time wisely between study, prayer and business of state. His great tolerance is shown by a letter to his son in which he says:

> For God's love my son and for the advantage of thy soul, let they (the slaves) be masters of their freedom and their own will; and in the name of the living God I entreat that no man disturb them; that they shall be as free as their thoughts to serve what Lord they please.[5]

Monks and clerical physicians appear to have filled the gaps which existed from the time the lay educational institutions declined until the universities made their appearance. They particularly

undertook the state care of the poor, which formerly had been performed by the *archiatri popularis* or municipal physicians.

By the close of the sixth century, most secular schools had disappeared and had been replaced by cathedral or monastic schools. In England, monastic schools were founded at Iona (565), at Oxford, at Cambridge (c. 670), at Whitby (675) and at Jarrow (678), and later at York, Winchester and Canterbury. In Ireland monastic schools were introduced by St. Patrick (c. 440). Among the famous European schools were those of Fulda, Herschau, Prum, St. Gall, Chartris, Tours, Weisenburg and Reichenau. It is not known whether medicine was included in the curriculum at any of these schools.

Clerical physicians belonged to the lower as well as the higher clergy. The Church at times declared the professional success of the lower clergy to be miracles and cannonized the parties concerned. In case of the death of one of these clerical physicians—indeed with other physicians, too— it was customary to place manuscripts of the writings of Galen, Hippocrates, etc., in his coffin. In later years (1131, 1162, 1212), the ranks of the higher clergy often produced well educated physicians, such as, John of St. Amand (c. 1200), Peter of Spain (died 1277) and Simon de Cordo (died 1330). When the practice of medicine was forbidden to the clergy, the decrees of councils were often ignored—even with regard to surgical operations which were strictly forbidden.

Various clerical physicians enjoyed Church benefits in return for which they were expected to instruct pupils gratis and to treat the sick without charge—a consideration, however, that was not always carried out. Hence Emperor Sigismund in 1406 enforced these regulations and declared: "The high Magistri in Physica treat no one gratuitously, and hence they are going to hell." Clerical physicians, in many cities, gave free advice on appointed days, chiefly in the vestibules of the churches where the sick were brought. That some of the priests did not perform their duties very zealously is evidenced by the decree of the Council of Vienna.[6]

The earliest hint of clerical participation in surgery is found in the alleged performance of a Caesarean section by Bishop Paul of Merida. It is related that Bishop Masona built a large hospital at Merida in 580. According to Neuburger, it is extremely probable that in this institution the influence of the Nestorians' skill in medicine made itself felt.

Following the conversion of the Aryan Visigoths to Catholicism (586), monastical and ecclesiastical instruction received a considerable impetus. We may assume definitely that institutions and monasteries were provided with several physicians. From the ecclesiastical schools came Isidorus Hispalensis (Bishop Isidore of Seville 570-636), one of the most educated men of the Middle Ages.[7]

It will be recalled that the Church had prohibited the monks from exercising their activities beyond the walls of the monasteries. The practice of medicine beyond the cloister introduced an element of commercialism in the priests' lives and kept them away from their religious duties. Frequently monks were called away to distant places to give medical attention to dignitaries of the Church and princes of state. Monks engaged in medical procedure traveled about more and more and returned to the monastery only for important holy days. Some of the ecclesiastical healers actually forgot their traditional opposition to the shedding of blood and engaged in surgery, and some even substituted drugs for prayer. Such practices finally culminated in the promulgation by the Council of Rheims which prohibited monks and ecclesiastics from practicing medicine outside their orders altogether; after the year 1219, no member of a religious order was permitted to go outside of the monastery to practice medicine.

Ecclesiastic medicine began to decline in the tenth century due to a number of factors, chief of which was the fact that the people lost faith in the monks on account of the behavior of some of their number. While monks generally observed the "Benedictine Rule" with regard to virtue, humility, obedience and hospitality and engaged in manual labor and intellectual work, there were some whose capacity for evil counterbalanced their desire to do good. Exempt from all civic authorities, some monks took advantage of their privileged status and became unruly. At times the monasteries became actual hotbeds of insubordination to the state and even to the Church. Part of this temptation to evil arose out of Church celibacy. On rare occasions, the conduct of certain monks actually occasioned public scandals.

Another great influence which led to the decline of monkish medicine was the rising belief in the medical efficacy of the invocation of saints

and relics. Every country had its saints and each saint had control over a certain disease or diseased organ. The healing power of saints was frequently exercised through relics in the shrines consecrated to them. These forms of healing were very costly and patients had to travel long distances and pay large sums for the privilege of employing them.

The Crusades, especially, brought an extended field of activity in the lay medical field. Innumerable hospitals were founded as a result of these military expeditions, and lay physicians ran these institutions. The great Hohenstaufer, Frederick II, enlightened by the wisdom of the Orient, was active in the promotion of education and especially in the elevation of the position of physicians. By his high regard for medical studies and educational institutions, he became a benefactor of mankind—especially in Italy. Through his medical ordinance, published in 1224, which paid no heed to the triple ban of Pope Gregory IX (1227-1241), he secured for himself an honorable place in the history of medical culture.

Roger, King of Sicily and grandfather of Frederick II, had already published an ordinance providing that the physician, before entering practice, must present himself to the civil magistrates and procure their permission, "in order that my subjects may not incur danger through the inexperience of the physicians." For violation of this ordinance the penalty of imprisonment and confiscation of all wordly goods was established. His grandson, Frederick II, enlarged upon the important regulations of Roger's ordinance and came up with the following:

Code of Physicians and Surgeons

A. To practice in all branches of medicine (and surgery also), and to bear the title of physician, is permitted only to him who has passed an examination at Salerno, and received the state-license from the Emperor or his viceroy. Violators of the law are to be punished by fines of money and goods, and receive one year's imprisonment.

B. Before a physician is admitted to an examination, he must have attended lectures in logic for 3 years, and in medicine and surgery for 5 years, and must have practiced under the direction of an experienced physician for one year.

C. Physicians are to be examined on the books of Hippocrates, Galen, and Avicenna.

D. To be approved, the surgeon is to bring evidence that he has attended the lectures of professors, and pursued for one year the curriculum which surgeons hold necessary, including a satisfactory course in human anatomy. Surgeons of the first class are to be examined by three professors, of whom one teacher of surgery is to conduct the examination in the Latin language, and in the presence of recognized authorities of the nation of the candidate. The diploma is to be signed by all these persons, accompanied by the attestation of a notary, and must bear the seal of the Faculty. Surgeons of the second class are to be examined in Italian and by two teachers only, and the diploma is then to be subscribed by the two examiners alone. Surgical candidates must take an oath never to treat internal disease, and they might never receive the title of doctor.

E. The physician must swear to give information of such fact if an apothecary sells adulterated drugs.

F. The physician must not be guilty of collusion with the apothecary as regards the price of drugs; still less might he keep a drug-store.

Fees of the Physician, According to the Code

A. The poor must be treated without charge.

B. The physician must visit his patients at least twice each day, and, if requested, once also at night. For this he receives for each day's treatment:

(1) In the city, or at his residence, half a *tarenus*.
(2) Away from his residence, when:
The patient paid his traveling expenses, 3 *tareni*
The doctor paid his traveling expenses, 4 *tareni*

Of Apothecaries, Druggists and Their Tariff

A. The druggists (confectionari) must compound and keep their drugs properly and in the prescribed method, which fact must be certified by physicians, and even confirmed by an oath. Contravention of this regulation is punished by seizure of goods and even by death.

B. The apothecaries (stationarii) must keep all regular drugs and simples for no longer than one year from the day of purchase; they can charge 3 *tareni* per ounce; for medicines requiring aging for more than one year, they are permitted to charge 6 *tareni* per ounce.

Apothecary-shops could be kept only at places designated throughout the kingdom.[6]

Theodoric's famous *Chirurgia* was originally published in the year 1267. Divided into four parts, this work deals with wounds, dislocations, fractures and hemorrhage. He suggests control of venous bleeding by pressure and arterial bleeding by ligature above and below the point of severance of the artery. He treats skull fracture by elevation and removal of the loose pieces. His handling of lacerations, with stitching and dry dressings left unchanged for four or five days, is suggestive of modern surgery.*

(Continued on Page 1034)

*Refer to fine English translation of the first two parts of Theodoric's Chirurgia by Eldridge Campbell and James Colton published in 1955 by Appleton and Company, New York.

National Shelter Policy

Federal Civil Defense Administrator Leo A. Hoegh has announced the Administration's national policy on shelters which is of vital concern to every doctor, every nurse and every hospital attendant. This policy is a significant progressive step in casualty care; namely, the prevention of the occurrence of casualties from radioactive fallout which would endanger millions of persons if nuclear attacks were unleashed against our homeland. Here are excerpts from Governor Hoegh's statement of May 7:

"The Administration has conducted exhaustive studies and tests—with respect to protective measures to safeguard our citizens against the effects of nuclear weapons. These several analyses have indicated that there is a great potential for the saving of life by fallout shelters. In the event of nuclear attack on this country, fallout shelters offer the best single non-military defense measure for the protection of the greatest number of our people. . . .

"The Administration's national civil defense policy, which now includes planning for the movement of people from target areas if time permits, will now also include the use of shelters to provide protection from radioactive fallout.

"To implement this established policy, the Administration will undertake the following action:

1. The Administration will bring to every American all of the facts as to the possible effects of nuclear attack, and inform him of the steps which he and his State and local governments can take to minimize such effects.

   The present civil defense programs for information and education will therefore be substantially expanded in order to acquaint the people with the fallout hazard and how to effectively overcome it. The public education program will include information on:

   (a) Nuclear weapons effects on people, plants and animals;

   (b) The provision of effective fallout protection, how to construct a fallout shelter and how to improvise effective shelter;

(c) Necessary measures for the protection of food and water;

(d) How to carry out radiological decontamination; and

(e) What governments—Federal, State and local—are themselves doing about fallout protection."

Surveys will be made of existing structures and facilities capable of providing fallout shelter, particularly in larger cities.

Research will be conducted to show how fallout shelters may be incorporated in existing, as well as in new buildings—whether in homes, other private buildings, or governmental structures. The Administration will construct a limited number of prototype shelters of various kinds, suitable to different geographical and climatic areas, which would have practical peacetime uses. Some of the prototype structures will be incorporated in new hospitals and in additions to existing hospitals.

As the FCDA Administrator points out, Federal example is an indispensable element to stimulate state, local government, and private investment for fallout shelters. He frankly explains:

"There will be no massive federally-financed shelter construction program, because of the many unsolved and complicated problems which still are under intensive study."

"Common prudence" he argues, "requires that the Federal government take steps to assist each American to prepare himself—as he would through insurance—against any disaster to meet a possible—although unwanted—eventuality. The national shelter policy is founded upon this principle. This approach will provide the stimulation necessary for the American people to make preparations for fallout protection."

Geo. W. Slagle.

President, Michigan State Medical Society

President's

Message

Editorial

"EXPERIENCE vs. COMMUNITY RATING" TO BE SIFTED

The Health Information Foundation of New York City announced on May 9, 1958 that it will finance a $36,000, eighteen-month study of "experience rating" in voluntary health insurance—the setting of charges or premiums according to varying use of services by different groups.

The grant for the study was approved by the Executive Committee of the Foundation which represents 200 drug, pharmaceutical, chemical and allied companies that sponsor the Health Information Foundation.

The object of the study is to investigate the differences between the bases for setting premiums and comparing their relative advantages for the public, the nonprofit plan, the insurance companies and the providers of health services; particularly important considering that 123,000,000 Americans are now protected with some form of health insurance and the number is increasing daily.

* * *

This item is of extreme importance to the Blue Shield program. The insurance companies are anxious to sell for the least possible premium rate and gladly accept the experience rating which eliminates those groups where there is uncommonly large usage. They can then sell to special groups where on account of favorable age, experience, exposure and other items, medical calls are fewer and the premiums can be made smaller.

The basic theory back of the establishment of Blue Shield plans always has been to make it possible for all persons to receive the benefit on an average, or community rating. In fact that concept allowed the program to start in the first place. If groups are to be specially selected, the older people and the handicapped—the ones who actually need the most care—will be unable to buy their insurance at all because the prices will automatically have increased. Michigan has never used the experience rating but always used the community rating, as do most other Blue Shield programs. We shall be interested in what this study shows. We cannot afford or allow these changes unless the profession wishes to abandon the very cases which first stimulated the program.

MONTHS OF DECISION

In the June issue of THE JOURNAL there was presented a very complete and comprehensive report of the work of Michigan Medical Service, involving over a year's intensive study; a survey of desires and wishes of the public; of our subscribers and of the doctors. A completely new concept and expression of the contract is being offered for subscription. A few of our members and some organized groups have protested that they were being asked to subscribe for a program which they had not themselves studied in detail.

This has been a year of tremendous decisions. After months of study by the Michigan Medical Service Board of Directors, by The MSMS Council, and by the various committees and study groups, the House of Delegates in April, 1957, authorized a complete rejuvenation of our whole medical care program. A stupendous work has been done. There has been an opinion study; conferences of committees with our members, including representatives of labor who represent half of our subscribers, and with official fee study committees, leading to the final contract and approval of the State Insurance Commissioner.

Meanwhile every committee or every group which wished was given a hearing by our hard-working committees in order to make as perfect as possible the offering and the contract. No final details could be published until the Insurance Commissioner had approved. Our State Society officers, the very busy Councillors, the President, President-elect, Executive officers, as well as administrative and directing officers of Michigan Medical Service, have visited every Councillor District in the state in recent months, answering any and all questions, explaining items and details as they developed. A most sincere effort has been made to reach every available member, to answer his questions, to allay his fears and to assure him that the program of the Michigan State Medical Society is a far step forward in medical history.

April was a month of decision. The Michigan State Medical Society House of Delegates on April 27, 1957, decided on a program, established a set of principles, and got to work. In April, 1958, the National Blue Shield Conference indicated a universal belief in and acceptance of a more extensive offering of medical service to the public. The Michigan program, then in development, was well received.

May was a month of decision. In Michigan and quite generally over the land, the contracts between labor and management were to be reviewed. Industrial conditions in the nation and in Michigan especially, have been in a series of declines covering several months, with an unusually high number of laboring people out of work. Contracts of practically all of the motor industries and their kindred groups are expiring the last days of the month and the first few days of June. Whether the profession wishes it or not, its services to the laboring groups and to the other groups were on the bargaining table. The Michigan State Medical Society believes it is now offering to management, and to labor as well as to its own members, a service which will adequately supply these needs. Its offering was finally approved by the State Insurance Commissioner on May 20, 1958.

June was a month of decision. The details of the Michigan program have been presented by mailing a copy of contracts and provisions to every member of the Society. Now every doctor in Michigan, representatives of labor and management, our subscribers in general, and especially our members must make the final decision. The American Medical Association June meeting has been held in San Francisco. Also an anniversary of the National Health Conference occurred in Washington. June is a very special month of decision.

* * *

How many of our members remember these names: Josephine Roche, George Baehr, M.D., Dean A. Clark, M.D., Wilber Cohen? Do they mean anything to you? Go back twenty years and you will find these names and others very much in evidence while the medical profession was desperately fighting "organized effort within and without the government" to establish "compulsory health insurance" for all the people. The American Labor Health Association held a meeting on June 16-17, this being a twentieth anniversary of the National Health Conference of 1938 which was presided over by Josephine Roche, at that time assistant secretary in charge of the United States Public Health Service. She will again be chairman. The gentlemen mentioned were all expecting to be present, and probably will still advocate "compulsory health insurance." Josephine Roche is now director of the UMWA's Welfare and Retirement Fund. George Baehr was the founder of New York's HIP. Dr. Dean A. Clark is president of the Group Health Federation. Dr. Wilber J. Cohen is professor of social work at the University of Michigan. He was the subject of a University of Michigan news release on December 10, 1957, in which he stated:

> "Total medical care and expenditures have quadrupled during the past twenty-five years. Per capita expenditures have tripled while the proportion of the total spent from public funds has more than doubled. Five per cent of our national income now goes for medical purposes. Total medical expenditures average about $100 per year for every man, woman and child in the nation. The total medical bill is over 17 billions for the whole country with a growing and aging population and a demand for more and better medical services. The expenditures will continue to increase. It will not be many years at the present rate until medical expenditures exceed 25 billions annually."

The American Medical Association has again taken a united stand against certain provisions of the Forand Bill and others which would further extend the numbers of persons now already receiving their health services through the federal government.

What the outcome of the AMA meeting and the National Health Conference will be, may possibly be suggested by further quotation of Professor Cohen:

> "Twenty-five years ago, the use of the insurance method was a controversial issue in medical care. This is no longer true; today the medical profession and the public wholeheartedly accept the insurance principle. Every effort is being made to extend it on a voluntary basis and to expand it to cover a larger proportion of people and a larger proportion of medical costs. Nevertheless a substantial proportion of low income persons at high cost services are still excluded from insurance coverage. It is doubtful that voluntary arrangements can or should cover these persons completely."

Congress has recognized the cost of providing medical care to 6 million recipients of public assistance as a national responsibility. The Social Security amendments of 1956 increased federal

financial aid for this group and to continue Professor Cohen's quote:

". . . an important piece of legislation which I trust congress will enact in 1958 is the proposal of the federal government to contribute to a comprehensive health insurance program for federal employes and their families. By this means, the federal government as an employer can assure that their own employes and their families will receive more adequate medical service. The federal government should set a standard for the guidance of voluntary plans and the individual states."

What of the Future?

Decisions have been made in Michigan. The Michigan State Medical Society and Michigan Medical Service have made the best offering possible to develop. The American Medical Association has made its decisions in San Francisco. The labor leaders, labor and management, have made and are making their bargaining programs. The pressure groups which have revised and rekindled the national health conference have made their decisions. If our medical profession will work as a unit—one profession with one objective—to serve our people adequately and as economically as possible, we have no fear of the future. Medical practice in European countries has fallen by the wayside because their leadership has been poor, their loyalty to the professional ideal inadequate, and their steadfastness of purpose faltering. The next few months will again be months of decision —our decision. Will our program work? It must.

SOME HISTORIC FACTS

One of the very pleasant and rewarding tasks of an editor is to record history in the making. This is especially true in medicine and Michigan has been making history for many years. Some committees have been working on the socio-economic feature of the practice of medicine involving the duty of a doctor not only to give medical service to his patients but to find methods by which the patients, and especially the lower income groups, shall be able to pay a reasonable measure of the medical bills.

These committees, changing membership, working in various places, finally became stymied by the legal implications and in the late 1930's turned to the MSMS Council for certain definite help in the nature of legal, actuarial and economic advice and use of insurance consultants to work out the "mutual health program" which had been evolved. This included enabling acts of the legislature and the establishment of Michigan Medical Service. The final work was a combination of a committee headed by Dr. Ralph H. Pino of Detroit, and The Council—resulting in recommendations to the House of Delegates with final adoption.

Michigan Medical Service was set up legally as a corporation of the state under its laws and enabling act, its membership consisting of members of the House of Delegates plus the elected directors. The Board of Directors, the majority of whom must always be doctors of medicine, is selected by the MSMS House of Delegates to represent the public, the medical profession and the Michigan Hospital Association. Legally, Michigan Medical Service is a corporation whose members have certain duties including the election of directors who must operate the corporation. Actually, it is also an integral part of the Michigan State Medical Society, having exactly the same function fundamentally as The Council, having the same membership body and being elected in the same way for specific terms of service. This situation must be remembered for a complete understanding.

Committees were established to draft a fair and reasonable fee schedule program and to construct a service contract to be offered to the public. The first such contract anticipated complete coverage so far as possible, to include home, office and hospital services with certain exemptions. But the first contract actually sold was to satisfy an acute need. The Ford Motor Company had available 40 cents per employe a month and asked what we could do for their workers. Michigan Medical Service believed that, considering the participation of our members and the guarantee to accept what fees we could pay for services to this group, that surgery in the hospital could be offered. The first month saw about 67,000 subscribers. That group of subscribers started the program, and from that number the group increased rapidly.

Next, Michigan Medical Service contracted with the State Highway Department for a complete coverage program which had been devised and which was to cover employes and their families. That program was in operation approximately two years but because of inadequate rates and especially of inadequate coverage—lost money (approximately $120,000) — was discontinued. Meantime, the surgical program had proven pop-

ular. After insufficient rates were finally adjusted, and Jay C. Ketchum had been hired as executive vice president, Michigan Medical Service was a success. It soon paid off the prorating indebtedness and a half million deficit.

THE YEAR'S ACCOMPLISHMENT

The years of growth in Michigan and of kindred plans throughout the nation passed rapidly. Over the years some of our Board members, some of our actuarial advisors and administrators, and many of the members had suggested that the program should be increased and liberalized. About three years ago that belief took active form. Committees representing The Council, the House of Delegates, Michigan Medical Service, and the Wayne County Medical Society finally stimulated the action of calling a special session of the House of Delegates. This movement was helped along by the Governor's Study Committee and the increasing demands of labor for more coverage.

The MSMS survey was taken, including direct questions and mailed questionnaires to the members of the Michigan State Medical Society. Active work of not only the survey committee, but of the committee representing the House of Delegates headed by C. I. Owen, M.D., of Detroit, and the committee representing the State Medical Society Council, of which George W. Slagle, M.D., of Battle Creek, was chairman, was begun. The reports finally presented to the House of Delegates and the action taken by the House, authorized and promised definite increased service to subscribers, increased fees to doctors, and a completely new concept of medical service.

The eight months from September, 1957, to May, 1958, saw the creation not only of a new service contract but a new method of economic administration, patient participation, and the adoption of a relative value fee schedule. Every member of the House, every county officer, every member of the Society, knew what was being done. The Secretary sent requests to each county society and to each special society, urging that they send in suggested fee schedules and their requests for hearing if needed, so that the new payment rates could be established, the contracts for Medicare be made, and the renewal of the Veterans Administration Home Town Medical Care Contract be consummated under the new fee schedule, with a deadline of March 1, 1958. These schedules of subscriber rates to be paid the relative value schedule and the precise and exact wording of the contract, all were involved in the enormous task done during these last few months and release of information all depended upon the acceptance by the Insurance Commissioner. *That completes that historic item.*

FEE SCHEDULES

The relative value fee schedule is a new name for a very old problem. As long ago as memory, medical groups, county medical societies, and others have established fee schedules. Some were secret, some open and above board, but about the time the federal antitrust law was arranged, the profession was given to understand there might be restraint of trade and the medical society rather frowned upon such schedules. However, the prepaid movement for medical care and the demand from the governmental agencies, the bureaucrats, certain doctors and certain labor organizations for a compulsory medical care program compelled the establishing of fee schedules.

The Michigan State Medical Society and Michigan Medical Service published a "Minimum Fee Schedule For Governmental Agencies" in 1947, establishing and readjusting schedules of the amounts Michigan Medical Service hoped it could pay members for specified, limited services which were rendered under Blue Shield.

About 1933 and 1934, the Calhoun County Medical Society adopted what they called a "unit fee schedule"—rating each service as near as they could to the relative importance, the relative responsibility, relative difficulty, relative risk, and the attempt not to reduce any already established rates. This was scheduled on a 100 per cent basis. Plans had been made to put into effect the "mutual health program" with that rating on July 1, 1934. The Society found difficulty in satisfying everyone, and being compelled to give up the whole program, because of infringing Michigan's insurance laws, surrendered that material to the Michigan State Medical Society executive office.

Later, working with Dr. Pino's committee, The Council formulated Michigan Medical Service, abandoned the unit rates and set up a payment program supposed to be adequate for the low income group they expected to insure, listing the amount which was hoped could be paid.

Accusation was made that the State Medical Society was setting up a uniform fee schedule. This was not true. The Society was setting up a schedule which they considered adequate under certain restricted terms of low income and for very restricted services. The growth of prepaid medical insurance idea and its general adoption by 42 million Blue Shield subscribers plus another 70 or 80 million general insurance groups, have made a schedule of fees an absolute necessity.

Michigan has not established a set fee schedule. Michigan has adapted California's relative value fee schedule with approximately 16,000 items, 492 of which were distributed May 20, with the interpolation of these relative values into money values for the three income rate contracts. These rates are published of necessity to govern payments, they are not compulsory. They are what is considered adequate pay for these particular services in these particular income groups and are what Michigan Medical Service is prepared to pay for services to its subscribers. This has nothing to do with the rates any individual doctor may charge his patient, but they are the rates payable to participating doctors.

Every single one of these items is set up for the average case. If any case or any service is unusual, takes extraordinary skill, exceptional time, or unusual hazard, the doctor has a perfect right to request individual consideration. Committees are being set up in the various Councillor districts with authority to pass upon such requests, to investigate and to make the decision.

A United Profession

This program outlined, and this very advanced step in medical economics history is the work of a united Michigan State Medical Society. Participation slips have been mailed to each member and to each doctor. In order to sell this service, our subscribers have a right to know and the Insurance Commissioner demands that sufficient numbers will administer the program as liberalized, so that no one may fail to receive services. It is hoped participation will be widely accepted. If sufficient numbers do accept and our new policy is subscribed to, there is every reason to believe that the movement for the government to take over the medical program, will again be staved off. The united action of our profession with cohesion and full trust, would avoid what has happened in so many other nations.

THE "BLUE SHIELD IDEA"

"I believe that the whole structure of voluntary health insurance is dependent upon Blue Shield. By that I mean that Blue Cross will not survive without Blue Shield, nor will the commercial insurance industry, especially the major medical part of it. Only a compulsory, regimented system can supplant this whole voluntary system, and the keynote to its survival is the Blue Shield idea". . . .

These words are quoted from a recent address by Dr. Donald Stubbs, of Washington, who currently serves as president of the District of Columbia's Blue Shield Plan and as chairman of the board of the national association of Blue Shield Medical Care Plans.

What is the "Blue Shield idea?" And why is this idea the keynote to the survival of our voluntary health insurance program in America?

First of all, the Blue Shield idea exemplifies medicine's *responsible service to the community.* It represents our profession's greatest and most successful effort to break the money barrier between patients of limited income and the professional services—of unpredictable amounts and incalculable costs—that we stand ready to provide them. It represents the one prepayment plan that seeks to protect, first of all, the least profitable "risks"—those people who can least afford our services and who, generally, most frequently need them.

Second, the Blue Shield idea is the idea of providing *dependable benefit to the patient.* Blue Shield Plan pays their "participating physicians" directly for services rendered Blue Shield member-patients. In most areas, these "participating physicians," through their agreements with their local Plans, have given assurance to their patients in the lower and moderate income groups that their Blue Shield membership will meet the full cost of services covered by their contracts. Even where Blue Shield payments are accepted by doctors on an "indemnity" basis, the Plans are constantly seeking to equate their payments to the normal fees of the local physicians—so that Blue Shield may offer the patient of limited means a reliable assurance that the Plan's payments will meet the actual costs of covered services.

Third, the Blue Shield idea is the idea of *preserving the private, confidential relationship* between doctor and patient. No "third party"

(Continued on Page 1029)

1958 Guest Speakers

David Adlersberg, M.D.

J. A. Bargen, M.D.

H. L. Bockus, M.D.

C. T. Beecham, M.D.

Willis E. Brown, M.D.

V. P. Collins, M.D.

John M. Craig, M.D.

O. S. Culp, M.D.

Helen O. Curth, M.D.

Windsor Davies, M.D.

A. J. Elliot, M.D.

O. Spurgeon English, M.D.

Harold F. Falls, M.D.

Stuart M. Finch, M.D.

A. B. French, M.D.

Harry Gold, M.D.

Perrin H. Long, M.D.

R. H. Marshak, M.D.

Waldo E. Nelson, M.D.

Hermann K. Pinkus, M.D.

Robert J. Priest, M.D.

R. A. Reis, M.D.

L. L. Robbins, M.D.

D. J. Sandweiss, M.D.

John W. Severinghaus, M.D.

Thomas L. Shipman, M.D.

J. R. Simpson, M.D.

James L. Wilson, M.D

Michigan State Medical Society

Past Presidents, 1866-1956

1866—*C. M. Stockwell, Port Huron
1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
1883—*A. F. Whelan, Hillsdale
1884—*Donald Maclean, Detroit
1885—*E. P. Christian, Wyandotte
1886—*Charles Shepard, Grand Rapids
1887—*T. A. McGraw, Detroit
1888—*S. S. French, Battle Creek
1889—*G. E. Frothingham, Detroit
1890—*L. W. Bliss, Saginaw
1891—*George E. Ranney, Lansing
1892—*Charles J. Lundy, Detroit
(Died before taking office)
*Gilbert V. Chamberlain, Flint
(Acting President)
1893—*Eugene Boise, Grand Rapids
1894—*Henry O. Walker, Detroit
1895—*Victor C. Vaughan, Ann Arbor
1896—*Hugh McColl, Lapeer
1897—*Joseph B. Griswold, Grand Rapids
1898—*Ernest L. Shurly, Detroit
1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson
1903—*Wm. F. Breakey, Ann Arbor
1904—*B. D. Harison, Sault Ste. Marie
1905—*David Inglis, Detroit
1906—*Charles B. Stockwell, Port Huron
1907—*Hermon Ostrander, Kalamazoo
1908—*A. F. Lawbaugh, Calumet
1909—*J. H. Carstens, Detroit
1910—*C. B. Burr, Flint
1911—*D. Emmett Welsh, Grand Rapids
1912—*Wm. H. Sawyer, Hillsdale
1913—*Guy L. Kiefer, Detroit
1914—*Reuben Peterson, Ann Arbor
1915—*A. W. Hornbogen, Marquette
1916—*Andrew P. Biddle, Detroit
1917—*Andrew P. Biddle, Detroit
1918—*Arthur M. Hume, Owosso
1919—*Charles H. Baker, Bay City
1920—*Angus McLean, Detroit
1921—*Wm. J. Kay, Lapeer
1922—*W. T. Dodge, Big Rapids
1923—*Guy L. Connor, Detroit
1924—*C. C. Clancy, Port Huron
1925—*Cyrenus G. Darling, Ann Arbor
1926—*J. B. Jackson, Kalamazoo
1927—*Herbert E. Randall, Flint
1928— Louis J. Hirschman, Detroit
1929—*J. D. Brook, Grandville
1930—*Ray C. Stone, Battle Creek
1931—*Carl F. Moll, Flint
1932— J. Milton Robb, Detroit
1933—*George LeFevre, Muskegon
1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936—*Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938—*Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943—*C. R. Keynort, Grayling
1944—*A. S. Brunk, Detroit
1945—*V. M. Moore, Grand Rapids
(Died before taking office)
1945—*R. S. Morrish, Flint
1946— Wm. A. Hyland, Grand Rapids
1947—*P. L. Ledwidge, Detroit
1948— E. F. Sladek, Traverse City
1949— Wilfrid Haughey, Battle Creek
(President-for-a-Day, Sept. 21, 1949)
1949—*W. E. Barstow, St. Louis
1950— C. E. Umphrey, Detroit
1951— Otto O. Beck, Birmingham
1952— R. L. Novy, Detroit
(President-for-a-Day, Sept. 22, 1952)
1952— R. J. Hubbell, Kalamazoo
1953— L. W. Hull, Detroit
1954— L. Fernald Foster, Bay City
(President-for-a-Day, Sept. 28, 1954)
1954—*R. H. Baker, Pontiac
1955— W. S. Jones, Menominee
1956— Arch Walls, Detroit

*Deceased.

Michigan State Medical Society

The Ninety-third Annual Session

SHERATON-CADILLAC HOTEL, DETROIT

September 28-October 3, 1958

ANNUAL SESSION INFORMATION

DIRECTORY

Headquarters—Sheraton-Cadillac Hotel, Detroit

Registration—for House of Delegates: Sheraton-Cadillac Hotel, Detroit, Grand Ballroom Foyer (Fourth Floor) Sunday, September 28, 6:00 p.m.

House of Delegates—Sunday, Monday-Tuesday, September 28-29-30, Fourth Floor Sheraton Cadillac Hotel

Press Room—Suite 500, Sheraton-Cadillac Hotel

Woman's Auxiliary Headquarters—Fort Shelby Hotel, Detroit

Michigan State Medical Assistants Society Headquarters Statler Hotel, Detroit

• **REGISTER**—Fifth Floor, Sheraton-Cadillac Hotel—soon as you arrive.

Hours:

Tuesday, September 30—12:00 noon to 5:15 p.m.
Wednesday, October 1—8:00 a.m. to 5:15 p.m.
Thursday, October 2—8:00 a.m. to 5:15 p.m.
Friday, October 3—8:00 a.m. to 1:30 p.m.

• **NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA AND CANADIAN MEDICAL ASSOCIATION.**

Admission will be by badge only to all Scientific Assemblies, Section Meetings, and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership card to expedite your registration. We wish to save your time.

• **MICHIGAN DOCTORS OF MEDICINE,** in practice but who are not members of MSMS, if listed in the American Medical Directory, may register as guests upon payment of $25.00. This amount will be credited to them as dues in the Michigan State Medical Society. **FOR THE BALANCE OF 1958 ONLY,** provided they subsequently are accepted as members by the County Medical Society in whose jurisdiction they practice.

• **C. I. Owen, M.D.,** of Detroit is General Chairman of the 1958 MSMS Annual Session.

• **TELEPHONE SERVICE**—Special lines to handle local and long distance telephone service for registrants at the MSMS meeting will be installed on the Fourth Floor near the Grand Ballroom, Sheraton-Cadillac Hotel. Call WOodward 1-8000.

• **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Assembly Chairman. This request is made in order to avoid confusion and disappointment on the part of members of the audience.

• **CHECK ROOM**—Fifth Floor, Sheraton-Cadillac Hotel near elevators.

• **DINNER DANCE**—Officers' Night—Wednesday, October 1, 1958. Reception at 7:00 p.m., Boulevard Lounge, and Dinner at 8:00 p.m. in Book Casino, both on lobby floor of Sheraton-Cadillac Hotel, Detroit. All registrants and their ladies are cordially invited (dress optional).

• **POSTGRADUATE CREDITS ARE GIVEN TO EVERY MSMS** member who attends the Annual Session.

• **TRANSPORTATION**—The C & O Streamliners afford a convenient means of transportation to the MSMS Annual Session in Detroit for hundreds of physicians located in the central and western parts of the State.

SECTION MEETINGS

TUESDAY, SEPTEMBER 30

Obstetrics-Gynecology
Pediatrics

WEDNESDAY, OCTOBER 1

Anesthesiology
Dermatology-Syphilology
Surgery
Urology

THURSDAY, OCTOBER 2

Gastroenterology-Proctology
General Practice
Nervous and Mental Diseases
Occupational Medicine
Ophthalmology
Otolaryngology
Public Health and Preventive Medicine

FRIDAY, OCTOBER 3

Medicine
Pathology

MICHIGAN MEDICAL SERVICE MEMBERS' MEETING

Blue Cross-Blue Shield Building
441 East Jefferson Ave., Detroit

Tuesday, September 29, 1958

(Coincident with MSMS Annual Session)

11:45, 12:00, 12:15, buses will leave Sheraton-Cadillac Hotel.
12 Noon-12:30 p.m.—"See Your Plan in Action"
12:30 p.m.—Preprandial—Private Dining Room, Fifth Floor
1:00 p.m.—Lunch
2:00 p.m.—Meeting of Corporation—Auditorium

All MSMS Delegates are members of Michigan Medical Service Corporation and are expected to attend the MMS Luncheon and Annual Meeting. The MMS Annual Meeting is open to ALL members of the medical profession who are cordially invited to attend.

• **PARKING**—Do not park on Detroit's streets. Inside parking at a convenient distance from the Sheraton-Cadillac Hotel, is available at the DAC Garage, 1754 Randolph, the Grand Circus Garage, 1776 Randolph, and the Book Tower Garage, 333 State Street.

• **CABARET-STYLE DANCE AND FLOOR SHOW,** with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom of the Sheraton-Cadillac Hotel at 9:30 p.m., Thursday, October 2. All who register, and their ladies, are cordially invited to attend.

• **THE SCIENTIFIC PRESS RELATIONS COMMITTEE** is composed of: H. F. Dibble, M.D., Detroit, Chairman; A. B. Gwinn, M.D., Hastings; J. J. Lightbody, M.D., Detroit; C. Allen Payne, M.D., Grand Rapids; A. E. Schiller, M.D., Detroit; C. L. Weston, M.D., Owosso.

• **THE HOUSE OF DELEGATES PRESS RELATIONS COMMITTEE** is composed of: J. J. Lightbody, M.D., Detroit, Chairman; L. Fernald Foster, M.D., Detroit; K. H. Johnson, M.D., Lansing; Max Lichter, M.D., Melvindale; C. Allen Payne, M.D., Grand Rapids.

• **THE MSMS HOUSE OF DELEGATES** convenes Sunday, September 28, at 8:00 p.m. Grand Ballroom, Sheraton-Cadillac Hotel; it will hold its second and third meetings on Monday, September 29, 9:00 a.m., and at 8:00 p.m.; its fourth and fifth meetings will be on Tuesday, September 30, at 9:00 a.m. and at 8:00 p.m.

QUESTIONS TO PARTICIPANTS ON MALABSORPTION PANEL

Please mail Questions direct to Moderator David J. Sandweiss, M.D., 15201 W. McNichols Road, Detroit 35.

To .....M.D.

Will you give consideration to the following questions?:

.....M.D.

• **PAPERS WILL BEGIN AND END ON TIME**—Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

• **THE TECHNICAL EXHIBITS** will open at 1:00 p.m. on Tuesday and at 9:30 a.m. on Wednesday, Thursday, and Friday; and close at 5:15 p.m., except on Friday when break-up is at 1:30 p.m. Frequent intermissions to view the educational exhibits have been arranged before, during, and after the Assemblies. Bring to the MSMS Convention a "WANT LIST" of your needs and place an order with an MSMS exhibitor.

• **THE HOLDER OF A HOTEL RESERVATION** who fails to show up . . . and fails to cancel his reservation . . . causes gastric hyper-peristalsis, hypersecretion of the hydrochloric acid, and rubus of the gastric mucosa to the hotel manager.

When convention reservations fill a hotel to the capacity, a room not occupied is a loss in $$$ that cannot be reclaimed.

The MSMS Annual Session always means a capacity house in the headquarters hotel.

Be kind to the hotel manager . . . be good to MSMS . . . be generous to your patients . . . be a friend to yourself—by showing up at the Sheraton-Cadillac Hotel, Detroit, for the four days of the MSMS Annual Session, September 30-October 1-2-3.

Order your hotel accommodations—today.

• **HENRY FORD MUSEUM AND GREENFIELD Village** extends a cordial welcome to all MSMS registrants. Three tours are available with chartered coach pick-up at hotel entrance. Special rate for group of 50 and more persons. For information, write Marshall L. Van Meter, Henry Ford Museum, Dearborn, Michigan.

MEETINGS OF SPECIAL SOCIETIES AND ALUMNI GROUPS

TUESDAY, SEPTEMBER 30

MSMS SECTION ON PEDIATRICS AND MICHIGAN BRANCH, AMERICAN ACADEMY OF PEDIATRICS—5:00 to 6:00 p.m. meeting; 6:00 p.m. reception; 7:00 p.m. dinner—all in the Sheraton-Cadillac Hotel.

ALUMNI ASSOCIATION, UNIVERSITY OF MICHIGAN MEDICAL SCHOOL—6:30 p.m. reception and dinner at 7:30 p.m., Sheraton-Cadillac Hotel.

MICHIGAN STATE SOCIETY OF CLINICAL HYPNOSIS (organization meeting), 7:30 p.m.—Sheraton-Cadillac Hotel.

INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE WILL BE FOUND at the Michigan State Medical Society Annual Session. All subjects on the MSMS Annual Session Program are applicable to clinical medicine. They stress diagnosis and treatment in everyday practice.

WEDNESDAY, OCTOBER 1

MICHIGAN REGIONAL COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS—12:00 M. luncheon followed by scientific meeting at 2:00 p.m.—Panel on "Athletic Injuries"—Sheraton-Cadillac Hotel.

MSMS SECTION ON UROLOGY AND DETROIT BRANCH OF THE AMERICAN UROLOGIC ASSOCIATION—5:00 p.m. meeting in the Sheraton-Cadillac Hotel.

MICHIGAN EPILEPSY CENTER AND ASSOCIATION LUNCHEON MEETING—beginning at 12:30 p.m.—Sheraton-Cadillac Hotel.

THURSDAY, OCTOBER 2

MSMS SECTION ON OTOLARYNGOLOGY AND THE DETROIT OTOLOGICAL SOCIETY—6:30 p.m. reception, 7:30 p.m. dinner, 8:30 p.m. scientific meeting—Sheraton-Cadillac Hotel.

MSMS SECTION ON NERVOUS AND MENTAL DISEASES—5:00 p.m. meeting followed by 6:30 p.m. reception and dinner at 7:30 p.m.—Sheraton-Cadillac Hotel.

MSMS SECTION ON OPHTHALMOLOGY—5:00 p.m. meeting followed by 6:30 p.m. reception and dinner at 7:30 p.m.—Statler Hotel.

ALUMNI ASSOCIATION, WAYNE STATE UNIVERSITY COLLEGE OF MEDICINE—6:45 p.m. reception and dinner—Sheraton-Cadillac Hotel.

MSMS SECTION ON GASTROENTEROLOGY AND PROCTOLOGY, THE MICHIGAN PROCTOLOGIC SOCIETY AND THE MICHIGAN GASTROENTEROLOGY SOCIETY—5:00 p.m. meeting—Statler Hotel.

ALPHA KAPPA KAPPA—8:00 a.m. breakfast-meeting, Sheraton-Cadillac Hotel.

MICHIGAN ACADEMY OF GENERAL PRACTICE BOARD OF DIRECTORS LUNCHEON MEETING at 12:00 noon Sheraton-Cadillac Hotel.

MSMS ADVISORY COMMITTEE OF PAST PRESIDENTS will hold a luncheon meeting in the Sheraton-Cadillac Hotel, beginning at 12:00 noon.

FRIDAY, OCTOBER 3

OTOLARYNGOLOGY - SURGICAL CLINICS — Tympanoplasty surgical clinic at Harper, Memorial and Henry Ford Hospitals on Friday afternoon, October 3, beginning at 1:00 p.m.

Because of the micro-surgical techniques involved, each clinic will be limited to eight guests. Please contact Dr. Harold F. Schuknecht, Secretary, Otolaryngology Section, MSMS, c/o Henry Ford Hospital, Detroit 2, for an assignment indicating your choice of clinic.

NERVOUS AND MENTAL DISEASE CLINICS—"Psychosomatic Problems" will be the subject of an interesting panel at Lafayette Clinic, Detroit, 2:00 to 4:00 p.m. Sponsors of the symposium will be the MSMS Section on Nervous and Mental Diseases in cooperation with Jacques S. Gottlieb, M.D., of the Lafayette Clinic.

O. Spurgeon English, M.D., Philadelphia, will be guest speaker at the Symposium.

MSMS SECTION ON PATHOLOGY AND MICHIGAN PATHOLOGICAL SOCIETY—2:00 to 5:00 p.m. scientific meeting followed by reception and dinner at 6:00 p.m. and a business meeting at 8:00 p.m.—Sheraton-Cadillac Hotel.

MICHIGAN DIABETES ASSOCIATION—one-half day symposium on Diabetes beginning at 2:00 p.m. Reception and dinner at 6:30 Sheraton-Cadillac Hotel.

MICHIGAN CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS AND MICHIGAN TRUDEAU SOCIETY. Reception and dinner at 6:30 p.m. followed by scientific session at 8:00 p.m.—Sheraton-Cadillac Hotel.

NEW INFORMATION IN THE EXHIBIT

Many items of interest or education will be found in the large exhibit of 103 technical displays. The Exhibit Section at MSMS Annual Sessions is as important informative and desirable to most doctors of medicine as the scientific papers presented in the Assembly room.

Doctor, stop at every booth—you'll be surprised how much you'll learn! No high-pressure salesman but a courteous well-informed exhibitor will greet you and supply you with some valuable information helpful to your patients.

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY

93rd Annual Session

Detroit, September 30-October 1-2-3, 1958

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to the Committee on Hotels for MSMS Convention, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Sheraton-Cadillac Hotel
Detroit, Michigan

Please make hotel reservation(s) as indicated below:

———— Single Room(s) ———— persons

———— Double Room(s) for ———— persons

———— Twin-Bedded Room(s) for ———— persons

Arriving September ———— hour ———— A.M. ———— P.M.

Leaving ———— hour ———— A.M. ———— P.M.

Hotel of First Choice: ————————

Second Choice: ————————

Names and addressees of all applicants including persons making reservations:

Name	Address	City	State

Date ———— Signature ————————

Address ———————— City ————

Michigan State Medical Society

The Ninety-third Annual Session

SHERATON-CADILLAC HOTEL, DETROIT

SEPTEMBER 30-OCTOBER 1-2-3, 1958

Program of Assemblies and Sections

TUESDAY AFTERNOON

September 30, 1958

First Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: WALTER Z. RUNDLES, M.D., Flint

Secretary: L. S. GRIFFITH, M.D., Grand Rapids

2:00 P.M.

"CHRONIC PELVIC PAIN"

WILLIS E. BROWN, M.D., Little Rock, Arkansas

Professor and Head of Department of Obstetrics and Gynecology, University of Arkansas Medical School

2:30 P.M.

"INFECTIONS IN THE NEWBORN"

WALDO E. NELSON, M.D., Philadelphia, Pennsylvania

Professor of Pediatrics, Temple University Hospital and School of Medicine; Medical Director, St. Christopher's Hospital for Children

Deaths within the first few weeks of postnatal life continue to account for approximately three-fourths of the relatively large number of fatalities of the first year. Furthermore, a number of the deaths in infants beyond one month of age are directly or indirectly related to perinatal factors. Estimates that neonatal deaths may be approaching an irreducible minimum in populations of good socio-economic status and with good medical care are not only premature but fraught with the dangers inherent in a state of smugness.

The lack of careful postmortem examinations is in part responsible for the failure to recognize the extent of the problem of infections in the newborn period.

An attempt will be made to appraise the situation as it is recognized at the moment, to illustrate the importance of approaching the problem on the basis of time of origin (prenatal, natal, postnatal) of the infection as well as of its etiology, and to relate these factors, where possible, to prevention as well as to therapy.

3:00 P.M.

INTERMISSION TO VIEW EXHIBITS

4:00 P.M.

"THE PROBLEM OF SPONTANEOUS ABORTION"

RALPH A. REIS, M.D., Chicago, Illinois

Editor "Obstetrics and Gynecology" and Professor of Obstetrics and Gynecology, Northwestern University Medical School

4:30 P.M.

"THERAPEUTIC CHANGES IN THE TREATMENT OF ENDOMETRIOSIS"

CLAYTON T. BEECHAM, M.D., Philadelphia, Pennsylvania

Clinical Professor of Obstetrics and Gynecology; Chief of Gynecologic Tumor Service, Temple University Medical School and Temple University Medical Center, Philadelphia

Twenty years ago Meigs editorialized his theory of the etiology on which we have been able to build a conservative therapeutic plan. He noted that endometriosis was common in private patients who married late and among whom contraceptive practices were widespread. By contrast, endometriosis was a rarity in ward patients in whom marriage took place earlier and contraceptive practices were practically non-existant. He theorized that the interruption of the rhythmic ovarian and uterine changes in aberrent endometrium by repeated early pregnancies must be beneficial and conversely, that prolonged periodic menstruation, without interruption favored the development of endometriosis.

Following this concept to the fullest has led to most satisfying therapeutic measures, each with a large share of conservative features.

The concept that castration is *necessary* to cure endometriosis is no longer tenable.

5:00 P.M.

END OF FIRST ASSEMBLY

WELL-KNOWN GUEST SPEAKERS

INTERESTING SECTION MEETINGS

OUTSTANDING EXHIBITS

You'll find them all

at the MSMS Annual Session

TUESDAY AFTERNOON

September 30, 1958

Program of Sections

Section on Obstetrics and Gynecology

5:00 to 6:00 P.M.

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: R. W. McCLURE, M.D., Detroit
Secretary: L. S. GRIFFITH, M.D., Grand Rapids

"PLANNED LABOR"

RALPH A. REIS, M.D., Chicago, Illinois

Section on Pediatrics and Michigan Branch, American Academy of Pediatrics

5:00 P.M. (Meeting)

6:30 P.M. (Reception and Dinner)

English Room, Sheraton-Cadillac Hotel

Chairman: A. M. HILL, M.D., Grand Rapids

Secretary: G. E. HAUSE, M.D., Detroit

"PULMONARY POTPOURRI"

WALDO E. NELSON, M.D., Philadelphia, Pennsylvania

The pediatrician must serve not only as a physician for children but also in a consultative capacity to the general practitioner in the solution of his pediatric problems.

From he latter type of experience we have assembled a variety of respiratory disturbances which presented problems in differential diagnosis. These will be illustrated and discussed from the standpoints of diagnosis and management.

WEDNESDAY MORNING

October 1, 1958

Second Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: WILLIAM S. JONES, M.D., Menominee
Secretary: THEODORE I. BOILEAU, M.D., Birmingham

9:00 A.M.

"REASONS FOR FAILURE OF TREATMENT AMONG 1,000 CASES OF CANCER OF THE BREAST"

VINCENT P. COLLINS, M.D., Houston, Texas

Professor and Chairman, Department of Radiology, Baylor University College of Medicine; Radiologist-in-Chief, Jefferson Davis Hospital

Radical mastectomy is the most commonly employed treatment for breast cancer but there are opposing views, strongly presented, as to how results may be improved. The proposal that more radical surgery should be undertaken to include the internal mammary region and the supraclavicular region is the antithesis of the policy of simple mastectomy and greater reliance on radiotherapy. The indications for radiotherapy and its value, in conjunction with radical mastectomy, are not agreed upon. That evidence is found in survival rates to support every view is suggestive of the need for further scrutiny of the behavior of this disease.

The records of approximately 1,000 patients who were referred for radio-thrapy have been reviewed. Two-thirds were operable patients treated primarily by radical mastectomy and one-third had inoperable lesions. These were studied with a view to determining the manner in which treatment failed and whether any other intervention might have altered the outcome. The pattern of recurrences and the manner of death in uncured patients demonstrate the direct effects of treatment and certain aspects of the course of the disease which are independent of the treatment offered. The findings indicate how conflicting observations may be reconciled and suggest the direction of possible improvement in the treatment for breast cancer by present methods.

9:30 A.M.

"PEPTIC ESOPHAGITIS"

J. ARNOLD BARGEN, M.D., Rochester, Minnesota
Chairman of Sections, Mayo Clinic

10:00 A.M.

INTERMISSION TO VIEW EXHIBITS

11:00 A.M.

"ANESTHESIA, ANOXIA, ACIDOSIS AND THE MYOCARDIUM"

JOHN W. SEVERINGHAUS, M.D., San Francisco, Calif.

Assistant Professor of Anesthesia, University of California Medical School

It has recently been shown that the myocardium is depressed far more by anesthetics, anoxia and acidosis than can be recognized by measurements of blood pressure, heart rate, or even cardiac output and venous pressure in normal subjects. This can be shown in dog heart lung preparations or in humans with in-

activated autonomic nervous systems such as may be done deliberately to reduce blood pressure during surgery. It is found that the myocardium is itself depressed in direct proportion to the depth of anesthesia, regardless of the agent. Normally several factors compensate for this depression, these being mediated through autonomic pathways to cause vasoconstriction, increased rate, and direct sympathetic stimulation of the myocardium. A new anesthetic, Fluothane, is of great interest since it does not call forth these autonomic compensations.

11:30 A.M. to 1:00 P.M.

PANEL ON "ULCERATIVE COLITIS AND ILEITIS IN CHILDREN"

Moderator:

JAMES L. WILSON, M.D., Ann Arbor, Michigan

Professor of Pediatrics, University of Michigan; Chairman of Department of Pediatrics and Communicable Diseases, University Hospital

Participants:

Title to be announced

J. ARNOLD BARGEN, M.D., Rochester, Minnesota

Chairman of Sections, Mayo Clinic

"PSYCHIATRIC ASPECTS OF ULCERATIVE COLITIS IN CHILDREN"

STUART M. FINCH, M.D., Ann Arbor, Michigan

Associate Professor of Psychiatry, University of Michigan Medical School, and Director of Children's Psychiatric Hospital.

The psychiatrist considers ulcerative colitis to be a psychophysiologic disorder. The complete evaluation of such a patient and the overall treatment plans should, therefore, include consideration of emotional problems. As is true with many psychophysiologic disorders, patients with ulcerative colitis suffer from deep and severe emotional problems which are often close to psychosis. Such symptomatology is often misunderstood by the nonpsychiatric physician and assumed to be an outgrowth of the disease rather than one of the etiological factors.

Children with ulcerative colitis can be divided into two groups from the standpoint of personality. The most common type is a rigid, compulsive, perfectionistic, highly intellectual youngster who expresses little emotion. The less common type is the manipulative, egocentric, emotionally unstable child who tends to use and abuse his colitis to gain his own ends. The former child usually has more severe bouts of colitis, but is somewhat easier to treat psychiatrically. The latter type of child often shows less dramatic physical symptoms. This child is much more difficult to treat psychiatrically.

The treatment of any child with a psychophysiologic disorder is complicated because it often requires the combined efforts of a psychiatrist and pediatrician. Each must understand the therapeutic techniques of the other.

1:00 P.M.

END OF SECOND ASSEMBLY

WEDNESDAY AFTERNOON

October 1, 1958

Third Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: EUGENE A. OSIUS, M.D., Detroit

Secretary: GLEN E. HAUSE, M.D., Detroit

2:00 P.M.

"DERMATOSES AND MALIGNANT INTERNAL TUMORS"

HELEN O. CURTH, M.D., New York City

Assistant Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Attending Dermatologist, Vanderbilt Clinic; Assistant Attending Dermatologist, Presbyterian Hospital, New York, N. Y.

This paper does not deal with cutaneous metatases of internal tumors but with benign dermatoses associated with malignant internal tumors. Recognition of these associations will help cancer research by providing material for an understanding of the principle by which a tumor has evoked cutaneous changes. It may also guide the physician in his search for a cancer preceded by a dermatosis.

The following cutaneous changes will be discussed:

Pruritus, flushing of skin, urticaria, acquired ichthyosis, pachydermoperiostosis, acanthosis nigricans, dermatomyositis, dermatitis herpetiformis, herpes zoster, erythema multiforme, erythem gyratum repens and cutaneous changes seen in association with intestinal polyposis. The type of internal tumor occurring in the various associations will be described. The genetic, mechanical, hormonal, toxic, allergic and other factors which play a role in the relationship between the tumor and the dermatosis will be discussed.

While disappearance of the dermatosis after removal of the tumor and reappearance of the dermatosis with return of the tumor point to a causal connection between tumor and the dermatosis it would be wrong to assume in every such instance the tumor to be the sole cause of the cutaneous eruption. The catabolic substances of the neoplasm may serve as the trigger mechanism for skin predisposed by genetic, allergic or other factors to various pathologic processes.

2:30 P.M.

"SIGNIFICANCE AND TREATMENT OF PROSTATIC NODULES"

ORMOND S. CULP, M.D., Rochester, Minnesota

Consultant in Urology, Mayo Clinic; Associate Professor of Urology, Mayo Foundation, University of Minnesota

Surgical extirpation continues to be the one hope for "cure" of prostatic cancer. Most of the suitable candidates for radical treatment are found to have an indurated area in the prostate during routine digital examination of the gland. To initiate or deny irreversible definitive therapy solely because of impressions derived from palpation of the prostate is fraught with danger. All nodules of so-called third degree induration are not malignant. Localized granulomatous prostatitis can be indistinguishable clinically from true carcinoma. This benign lesion occurs much more frequently than has been appreciated.

Needle biopsies and those obtained transurethrally have serious limitations and definite contraindications. Open biopsy via the perineum offers the best opportunity for adequate appraisal of prostatic nodules. The combination of frozen section examination and simultaneous prostatectomy of appropriate type has no parallel in other diagnostic or therapeutic schemes. However, several objections have been made to this theoretically ideal one-stage procedure. Personal experiences during the past eight years have been reviewed in an effort to determine the validity of such objections.

Even though total prostatectomy may seem to be the treatment of choice in selected cases, there must be strict adherence to rigid criteria in the choice of candidates or the operation will be abused as it has been in the past.

3:00 P.M.

INTERMISSION TO VIEW EXHIBITS

4:00 P.M.

"TREATMENT OF HEMANGIOMAS AND NEVI"

THEODORE K. LAWLESS, M.D., Chicago, Illinois

4:30 P.M.

"THE INFECTED SURGICAL WOUND"

R. C. HARRISON, M.D., Edmonton, Alberta, Canada

5:00 P.M.

END OF THIRD ASSEMBLY

OFFICERS NIGHT DINNER DANCE

Wednesday, October 1

Sponsored by the

Michigan State Medical Society

and the

Woman's Auxiliary

Boulevard Lounge and Book-Casino

Sheraton-Cadillac Hotel

Limit of 250

WEDNESDAY AFTERNOON

October 1, 1958

Program of Sections

Section on Urology and Detroit Branch, American Urological Association

5:00 to 6:00 P.M.

Sheraton Room, Sheraton-Cadillac Hotel

Chairman: H. V. MORLEY, M.D., Detroit

Secretary: A. W. BOHNE, M.D., Detroit

"POTENTIALITIES OF PARTIAL NEPHRECTOMY"

ORMOND S. CULP, M.D., Rochester, Minnesota

Various amounts of renal cortex have been excised for many reasons. Partial nephrectomy is now a well established procedure that has been employed advantageously in a great variety of situations. Nevertheless it has not attained the degree of popularity that it deserves.

Experiences with partial nephrectomy over an extended period are reviewed. These include both common and unique clinical applications. There is overwhelming evidence that the true potential of this surgical procedure has not been realized. The operation is not devoid of pitfalls and complications but most of the serious sequelae can be avoided by appropriate precautionary measures.

Section on Surgery

5:00 to 6:00 P.M.

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: H. M. BISHOP, M.D., Saginaw

Secretary: R. F. SALOT, M.D., Mt. Clemens

"PROBLEM OF ARM EDEMA POST MASTECTOMY"

VINCENT P. COLLINS, M.D., Houston, Texas, and R. C. HARRISON, M.D., Edmonton, Alberta, Canada

Followed by fifteen-minute Question and Answer Period

Section on Anesthesiology

5:00 to 6:00 P.M.

Pan American Room, Sheraton-Cadillac Hotel

Chairman: R. B. SWEET, M.D., Ann Arbor

"MONITORING DEVICES IN THE OPERATING ROOM"

JOHN W. SEVERINGHAUS, M.D., San Francisco, Calif.

Miniaturization of electronic equipment now offers great advantages to anesthesiologists for routine use. Transistorized electrocardiograph monitors which can fit in a breast pocket and audibly signal each heart beat, using flashlight sized batteries and only two skin leads are now possible. Pulse monitors strapping to a finger signal the presence of adequate blood pressure, and may replace the stethoscope for pressure measurement. Even the electroencephalograph and recording electrocardiograph have been reduced in size to facilitate routine use, one instrument now being no larger than a portable typewriter case. Ventilators have been designed permitting observation of the actual tidal volume. The increasing simplicity of some of these safety devices strongly argues their introduction into routine anesthesia practice.

Section on Dermatology and Syphilology

5:00 to 6:00 P.M.

Parlors G and H, Sheraton-Cadillac Hotel

Chairman: COLEMAN MOPPER, M.D., Detroit

Secretary: ALICE E. PALMER, M.D., Detroit

"THERAPY OF SKIN CANCER IN THE LIGHT OF NEWER HISTOBIOLOGIC CONCEPTS"

HERMANN K. PINKUS, M.D., Monroe, Michigan

Acting Chairman, Department of Dermatology, Wayne State University College of Medicine

It has been the traditional goal of the dermatologist to treat skin cancer by choosing that method among several available that promises safe cure with the minimum of morbidity and deformity. Standards of treatment have changed over the decades, and in general the trend has been toward higher doses of irradiation and more extensive surgery in order to prevent recurrences. Histopathologic examination has become the accepted guide by which to determine diagnosis, prognosis, and method and dosage of treatment. It therefore appears important to discuss recent changes in histobiologic concepts of various types of cutaneous malignancy which are of practical importance for the clinician. The following topics will be considered: pigmented nevus vs. malignant melanoma vs. juvenile melanoma; basal cell carcinoma and basal-squamous carcinoma vs. adnexal epithelioma; keratoacanthoma vs. low grade squamous cell carcinoma; inflammatory irritation in seborrheic keratosis vs. malignant transformation; and lichen sclerosus et atrophicus vs. leukoplakia in kraurosis vulvae. Rational management of these dermatoses will be outlined on the basis of their histologic structure and biologic behavior.

WEDNESDAY EVENING

October 1, 1958

Officers Night

7:00 P.M.

Reception—Boulevard Lounge, Sheraton-Cadillac Hotel

8:00 P.M.

Officers Night Dinner Dance—Book-Casino, Sheraton-Cadillac Hotel

L. FERNALD FOSTER, M.D., *Toastmaster*

1. **Announcements and brief report of House of Delegates actions**
2. **Induction of New Officers**
3. **President's Annual Address by George W. Slagle, M.D., Battle Creek**

MISS ANN LANDERS, Chicago

4. **Address of the evening: Miss Ann Landers, Columnist, Chicago Sun Times Syndicate**

Speakers like to hear from their audiences. If you especially enjoy certain presentations, write the lecturers and tell them. Obtain addresses from the MSMS Press Room.

THURSDAY MORNING
October 2, 1958

Fourth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: JAMES H. FYVIE, M.D., Manistique
Secretary: HUGH B. ROBINS, M.D., Battle Creek

9:00 A.M.

"PRACTICAL POINTS IN THE CARE OF THE CHILD IN THE FIRST YEAR OF LIFE"

LLOYD E. HARRIS, M.D., Rochester, Minnesota

9:30 A.M.

"USES AND ABUSE OF TRANQUILIZING DRUGS"

HARRY H. WAGENHEIM, M.D., Philadelphia, Pa.

10:00 A.M.

INTERMISSION TO VIEW EXHIBITS

11:00 A.M.

"PREVENTIVE ASPECTS OF DIABETES"

HUGH L. C. WILKERSON, M.D., Boston, Massachusetts

Chief, Diabetes Field Research, Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

11:30 A.M.

Medicine Panel on "MALABSORPTION SYNDROME AND DIARRHEA"

Moderator:

DAVID J. SANDWEISS, M.D., Detroit, Michigan

Chief of Section on Gastroenterology and Attending Physician in Medicine, Sinai Hospital; Physician in Internal Medicine, Harper Hospital; Associate Physician in Medicine, Receiving Hospital; Assistant Clinical Professor, Wayne State University College of Medicine.

Participants:

DAVID ADLERSBERG, M.D., New York City

Associate Attending Physician for Metabolic Disease, The Mt. Sinai Hospital, N. Y. C.; Assistant Clinical Professor of Medicine, College of Physicians and Surgeons, N. Y. C.

Primary malabsorption syndrome includes several clinical entities: Celiac disease of childhood, tropical sprue and non-tropical sprue. It must be strictly separated from the secondary malabsorption syndrome caused by gross involvement of the small bowel by lymphosarcoma, amyloidosis and jejunoileitis, or resulting from extensive resection of the small bowel or from liver or pancreatic disease.

The outstanding symptoms of non-tropical sprue are diarrhea, weakness, weight loss, glossitis, abdominal distention and, not infrequently, hemorrhagic manifestations, tetany, parathesias and bone pain. The diagnosis is based on the presence of steatorrhea, anemia and exclusion of the above-mentioned disease causing secondary malabsorption.

A characteristic pattern of the small bowel on x-ray examination ("sprue pattern"), flat glucose and vitamin A tolerance tests hypocholesteremia, hypocalcemia, osteomalacia and certain findings in the peripheral blood and bone marrow support the diagnosis.

The treatment of primary malabsorption syndrome is essentially empiric. It consists of a high-protein diet limited in fats and carbohydrates and supplemented with vitamin B_{12}, folic acid, liver extract or iron. More recently, satisfactory results have been achieved in children and adults with the use of a gluten-free diet. This dietary regimen excludes strictly wheat, rice, oats and barley. It is based on the concept that patients with primary malabsorption syndrome exhibit an abnormal sensitivity to gluten. In severe refractory cases of non-tropical sprue, satisfactory results have been obtained with adrenal corticosteroids. When used in small doses, these hormones may be given over prolonged periods of time and may control satisfactorily the manifestations of the disorder.

HENRY L. BOCKUS, M.D., Philadelphia, Pennsylvania
Professor and Chairman, Department of Medicine and Gastroenterology, Graduate School of Medicine, University of Pennsylvania; President, World Gastroenterological Association

ARTHUR B. FRENCH, M.D., Ann Arbor, Michigan
Assistant Professor of Internal Medicine; Member, Gastrointestinal Laboratory, University of Michigan Medical School

RICHARD H. MARSHAK, M.D., New York City
Associate Radiologist, Mt. Sinai Hospital

ROBERT J. PRIEST, M.D., Detroit, Michigan
Associate, Gastrointestinal Division, Henry Ford Hospital

1:00 P.M.

END OF FOURTH ASSEMBLY

THURSDAY AFTERNOON
October 2, 1958

Fifth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: SHERWOOD R. RUSSELL, M.D., St. Johns, Michigan

Secretary: VIOLA G. BREKKE, M.D., Highland Park, Michigan

2:00 P.M.

The Andrew P. Biddle, M.D., Lecture

"FUNCTIONAL DISORDERS OF THE DIGESTIVE TRACT"

HENRY L. BOCKUS, M.D., Philadelphia, Pennsylvania

Professor and Chairman, Department of Medicine and Gastroenterology, Graduate School of Medicine, University of Pennsylvania; President, World Gastroenterological Association

The following outline will be followed: (1) Definition and incidence of functional disorders. (2) Structural-functional interrelationships. (3) Functional disorders and the emotions. A. Experimental evidence. B. Clinical Observations. (4) Mechanism of abdominal complaints in relation to disturbed function. (5) Common functional disorders—their clinical orientation.

2:30 P.M.
"THE DOCTOR-PATIENT RELATIONSHIP"
LEWIS L. ROBBINS, M.D., Glen Oaks, New York
Director of Professional Services, Hillside Hospital, Glen Oaks, N. Y.

3:00 P.M.
INTERMISSION TO VIEW EXHIBITS

4:00 P.M.
"OCULAR AIDS IN DIAGNOSIS OF METABOLIC DISEASE"
ALFRED J. ELLIOT, M.D., Toronto, Ontario, Canada
Professor and Head of Department of Ophthalmology, University of Toronto

The important ocular indications of metabolic disease will be reviewed briefly, also their rôle in solving some of the problems with which the general practitioner is often confronted will be outlined. The rôle of the headache complaint will also be discussed.

Certain bedside optical aids which assist in clinical diagnosis will be demonstrated. The lecture will be illustrated with colour slides.

4:30 P.M.
"CAN YOU ANSWER YOUR PATIENTS' QUESTIONS ABOUT RADIATION?"
THOMAS L. SHIPMAN, M.D., Los Alamos, New Mexico
Health Division Leader, Los Alamos Scientific Laboratory

For a number of years it was almost unheard of for patients to inquire about the biological and genetic effects of radiation. That situation has changed completely and patients are not only confused and curious about many forms of radiation, including fallout from weapon testing, but also in some cases apprehensive about exposure to diagnostic x-rays. This paper will touch on a few specific points and stress the necessity for the medical professions becoming better acquainted with facts of radiation in general and becoming better informed concerning the orders of magnitude of various types of exposure to radiation.

5:00 P.M.
END OF FIFTH ASSEMBLY

THURSDAY AFTERNOON
October 2, 1958

Program of Sections

Section on Public Health and Preventive Medicine

5:00 to 6:00 P.M.
Sheraton Room, Sheraton-Cadillac Hotel
Chairman: J. K. ALTLAND, M.D., Lansing
Secretary: H. B. ROBINS, M.D., Battle Creek

"DIABETES MELLITUS AS A CHRONIC DISEASE"
HUGH L. C. WILKERSON, M.D., Boston, Mass.

Section on Gastroenterology and Proctology, Michigan Proctologic Society and Michigan Gastroenterology Society

5:00 to 6:00 P.M.
Parlor F, Statler Hotel

Chairman: E. J. TALLANT, M.D., Detroit
Secretary: J. F. WENZEL, M.D., Detroit

"PANCREATITIS"
HENRY L. BOCKUS, M.D., PHILADELPHIA, Pennsylvania

Section on Nervous and Mental Diseases

5:00 P.M. (Meeting)

6:30 P.M. (Reception and Dinner)

English Room, Sheraton-Cadillac Hotel

Chairman: S. C. MASON, M.D., Ann Arbor
Secretary: S. M. GOULD, JR., M.D., Ann Arbor, Michigan

"PSYCHOTHERAPY RESEARCH"
LEWIS L. ROBBINS, M.D., Glen Oaks, New York

Section on Ophthalmology

5:00 P.M. (Meeting)

6:30 P.M. (Reception and Dinner)

Bagley Room, Statler Hotel

Chairman: H. A. DUNLAP, M.D., Detroit
Secretary: F. A. BARBOUR, M.D., Flint

Panel on "DISORDERS OF THE MACULA"

"THE LESION OF THE MACULA AND PERIMACULAR AREA ASSOCIATED WITH EARLY CHILDHOOD"

HAROLD F. FALLS, M.D., Ann Arbor, Moderator
Associate Professor of Ophthalmology and Associate Geneticist

A "REFRESHER COURSE" OF GREAT VALUE TO PRACTITIONERS—THAT'S THE MSMS ANNUAL SESSION!

Participants:

"THE PATHOLOGY OF LESIONS IN AND ABOUT THE MACULAR AREA"

WINDSOR S. DAVIES, M.D., Detroit, Michigan
Professor of Clinical Ophthalmology, Wayne State University College of Medicine; Chief, Pathology Department, Kresge Eye Institute

and

"THE LESIONS OF THE MACULA AND PERIMACULAR REGION OF INVOLUTIONAL AND SENILE ORIGIN"

ALFRED J. ELLIOT, M.D., Toronto, Ontario, Canada

Section on Otolaryngology and Detroit Otological Society

6:30 P.M. (Reception and Dinner)

8:00 P.M. (Meeting)

Sheraton Room, Sheraton-Cadillac Hotel

Chairman: JAMES E. COYLE, M.D., Detroit
Secretary: HAROLD F. SCHUKNECHT, M.D., Detroit

Title to be announced

JOSEPH A. SULLIVAN, M.D., Toronto, Ontario, Canada

Section on General Practice

5:00 to 6:00 P.M.

Pan American Room, Sheraton-Cadillac Hotel

Chairman: E. M. WAKEMAN, M.D., Dearborn
Secretary: C. W. ROYER, M.D., Battle Creek

"GENERAL PRACTITIONER'S ROLE IN IMPROVEMENT OF MENTAL HEALTH"

HARRY H. WAGENHEIM, M.D., Philadelphia, Pa.

Section on Occupational Medicine

5:00 to 6:00 P.M.

Parlors G and H, Sheraton-Cadillac Hotel

Chairman: P. B. RASTELLO, M.D., Detroit
Secretary: T. I. BOILEAU, M.D., Birmingham

"HIDDEN OCCUPATIONAL HAZARDS IN INDUSTRIAL PROCESSES"

HENRY J. KREULEN, M.D., Grand Rapids, Michigan

EVERYONE YOU KNOW IS VIEWING THE EXHIBITS—JOIN THEM

THURSDAY EVENING
October 2, 1958

State Society Night

9:30 P.M.

Grand Ballroom, Sheraton-Cadillac Hotel

An evening of entertainment for all registrants, their ladies and guests
Cabaret-style Dance and Floor Show
Host: Michigan State Medical Society

FRIDAY MORNING
October 3, 1958

Sixth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: FRANCIS W. DWYER, M.D., Detroit
Secretary: EVERAL M. WAKEMAN, M.D., Dearborn

9:00 A.M.

"THE ABUSE OF ANTIBIOTIC THERAPY"

PERRIN H. LONG, M.D., Brooklyn, New York

Professor of Medicine, State University of New York, Downstate Medical Center

It is difficult to tell where the use of antibiotics will end. We administer them to our patients. We feed them to our fowl and to our hogs. We preserve our fowl for marketing with them, and shortly they will be used to preserve fish and shellfish. They are sprinkled on our vegetables and flowers to keep them from becoming blighted. Truly, we can ask, what about antibiotics?
The uses and abuses of these substances will be discussed.

9:30 A.M.

"FATAL COXSACKIE INFECTIONS IN INFANTS"

JOHN M. CRAIG, M.D., Boston, Massachusetts
Assistant Professor of Pathology, Harvard Medical School; Pathologist, Children's Hospital, Boston

Fatal Coxsackie infections in the newborn and young infant have now been recognized related to sporadic familial infections, as epidemics in newborn nursery populations or as isolated instances of fatal myocarditis in the older infant. Three instances of fatal Coxsackie infection in the neonatal period have been identified with widespread nervous system and visceral lesions. The clinical and pathologic implications of these will be discussed.

10:00 A.M.

INTERMISSION TO VIEW EXHIBITS

11:00 A.M.

"TYMPANOPLASTY"

JOSEPH A. SULLIVAN, M.D., Toronto, Ontario, Canada

11:30 A.M.

"PREPARATION OF PATIENT FOR MEDICAL AND SURGICAL PROCEDURES"

O. SPURGEON ENGLISH, M.D., Philadelphia, Pennsylvania

Professor and Head of Department of Psychiatry, Temple University Medical Center

To deal psychologically with patients in need of medical and surgical procedures, the physician should be aware of the many fantasies that surround hospitals and physicians themselves. It is unwise for the physician to assume that a strong physique or a robust or nonchalant personality is without these fantasies.

Everyone, and it seems appropriate to use a generality here, has his fears or apprehensions.

These fears have to do with pain—the pain of being ill. In both acute and chronic illness there is a fear of being helpless and having to be cared for. (Some may like this unconsciously but still feel, consciously, the need to protect against it.) Chronic illness often has "dangerous" names associated with it such as cancer, heart disease, tuberculosis or brain tumor. Underneath all disease runs the fear of death. Additionally, there is the problem, in hospitalization, even if only for a short time, of separation from home and relatives and the comforts one has been used to. There is the conflict of adjusting to hospital rules, the conflict of cost of treatment of surgery. There is conflict over the time involved which means a loss of money and livelihood, not to mention the guilt that may come from depriving other family members of tangible gratification through illness of the patient.

The added drama and urgency which surgery often necessitates may anaesthetize the patient to some of his problems for a few days but they reappear when convalescence gets underway. The surgeon should understand and be able to deal with the matter of pre and post operative discomforts, psychologically, as well as medically and surgically. Finally, a great psychological factor is involved in the proper time for the patient to return to work. This decision is often left to the patient or left undiscussed with great harm to the patient.

12:00 M.

"HUMAN PHARMACOLOGY"

HARRY GOLD, M.D., New York City

Professor of Clinical Pharmacology, Cornell University; Attending Physician and Chairman of the Cardiac Clinic, Hospital for Joint Diseases; Attending Physician-in-Charge-Cardio-Vascular Research Unit, Beth Israel Hospital

The unprecedented advances in recent years in the chemical isolation of pure compounds from natural sources and the synthesis of new ones have resulted in thousands of potent agents and mixtures with potential utility for the treatment of disease. The challenge to pharmacologists, medical practitioners, and students of therapeutics, to keep apace, to sort out those that are safe and useful and represent genuine therapeutic progress, has been commonly met in two ways: (1) screening in laboratory animals utilizing some specific mechanism such, for example, as the effect on the diffusion rate of a dye across the synovial membrane of the cat for the most promising cortical steroid as an anti-inflammatory drug, or the testing of compounds on artificially induced disorders or diseases in laboratory animals as, for example, arthritis by the injection of formaldehyde in the rat or cardiac fibrillation induced by cyclopropane and epinephrine in the cat or dog; and (2) the conventional "clinical trial" in which the new materials are evaluated in the setting of the practical care of patients. The laboratory animal screening methods supply important insight into the mechanisms of drug action but the yield in terms of therapeutic utility based on predictions from such studies has been meager and disappointing, chiefly because the response to drugs differs with the species of animal and the artificially induced diseases usually bear only partial identity with the natural diseases in man. The conventional "clinical trial" also falls short of the objective, being substantially the method of therapeutics, which is not a science but an art, involving several items, chemical, physical, and psychological, simultaneously applied, and in which the orientation is the cure of the patient without regard to the deciding factor. The evaluation of new drugs under these conditions yields only a suggestive mass of clinical impression from which it is quite impossible to sort out the part played by the pharmacologic actions of the new drugs. In the face of these difficulties, a relatively new discipline has emerged, the science of human pharmacology. It involves experimental techniques adapted to ascertain decisive qualitative and quantitative facts about drug actions, directly in humans and human diseases, methods so designed as to obtain the maximum information from a minimum number of patient-participants and in the shortest period of time. In these designs special attention is paid to such matters as the rôle of suggestion in the effects of drugs, the problems of patient and physician bias, the placebo, the "double-blind" technique, the cooperation of the patient, proper safeguards for the participant's welfare, bioassay, statistical validation of data, and the ethical aspects of experimental investigation in humans. Some of these problems will be illustrated from our experiences in human pharmacology.

12:30 P.M.

Title to be announced

FRANK B. KELLY, JR., M.D., Chicago, Illinois

1:00 P.M.

END OF SIXTH ASSEMBLY

1:00 P.M.

FINAL INTERMISSION TO VIEW EXHIBITS

FRIDAY AFTERNOON

October 3, 1958

Program of Sections

Section on Pathology and Michigan Pathological Society

2:00 to 5:00 P.M. (Meeting)

6:00 P.M. (Reception and Dinner)

8:00 P.M. (Business Meeting)

English Room, Sheraton-Cadillac Hotel

Chairman: VIOLA G. BREKKE, M.D., Highland Park

"THE NATURE AND SIGNIFICANCE OF PULMONARY HYALINE MEMBRANES IN NEONATAL ASPHYXIA"

JOHN M. CRAIG, M.D., Boston, Massachusetts

The nature and significance of the pulmonary hyaline membranes in the pathogenesis of respiratory insufficiency and asphyxia in the newborn has been long debated. It has been shown by immunofluorescent techniques that such membranes are composed chiefly of fibrin. By the use of injection and plastic reconstructions it has been shown that such membranes are truly obstructive to the passage of air into the alveolar spaces. The investigation of the respiratory dynamics in such infants and of their lungs obtained at postmortem are entirely consistent with the above interpretations.

Section on Medicine

1:00 to 1:30 P.M.

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: J. M. KAUFMAN, M.D., Detroit
Secretary: J. W. HALL, M.D., Traverse City

"LACTIC OEHYDROGENASE AS AN AID IN DIAGNOSIS OF CORONARY ARTERY DISEASE"

JOHN R. SIMPSON, M.D., Birmingham, Michigan

END OF 1958 ANNUAL SESSION

THE "BLUE SHIELD IDEA"

(Continued from Page 1014)

enters into the Blue Shield transaction between doctor and patient. The Blue Shield is the doctor's own mechanism, created in his own image, and dedicated to the sole purpose of helping the doctor the better to serve his patients. Blue Shield pays no tribute in the form of profits to third party owners; nor is Blue Shield subservient to the whims of social theorists who want to reshape medical practice to suit their own ideologies, or to the vote-catching designs of politicians.

Service to the community . . . dependable benefit to the patient . . . the private, confidential relationship of doctor and patient—these are the exclusive hallmarks of Blue Shield, and the bulwark of our voluntary plan of medical care prepayment in America.

The Blue Shield idea is rooted in the vital needs of the human being and in the best aspirations and traditions of the physician.

PERIODIC HEALTH SURVEYS

For nearly two years, THE JOURNAL has published short papers by prominent members directing attention to the advisability of periodic health surveys by the family physician and outlining what not to miss. The profession's leaders have practiced such a program for a great many years to a limited degree.

An appraisal of periodic health examination, prepared for publication by the Institute of Industrial Health of the Department of Medicine, Medical School, University of Michigan, Ann Arbor, concerns 500 executives, mostly male with an average age of forty-eight, who underwent a comprehensive examination lasting four days. Of these, 41 per cent were found to have abnormalities which they did not know about, 11 per cent had diseases they already knew about which demanded attention, and 25 per cent had conditions not serious. Forty-five per cent had gastrointestinal abnormalities, 24 per cent were cardiovascular and 18 per cent had nose and throat affections.

Of the group having previously unknown conditions, four had carcinoma (prostate, lung, colon, and skin), twenty-seven had hypertension, sixteen peptic ulcer, twelve gallstones, eight organic heart disease, and three diabetes.

This preliminary report confirms the attitude of the Michigan State Medical Society that periodic health examinations are desirable—even though some of our doctors believe they are too busy with other matters to give them. Nothing is more important than the recognition of the seventy out of 500 mentioned above. This is much too high a percentage to overlook.

Twenty per cent of these diagnoses could not be made on history and physical examination alone but demanded laboratory confirmation.

PLANNING FOR THE FUTURE

The past half century has witnessed the greatest scientific advances in history. At this moment the United States is upon the threshold of economic abundance. This is the era of a rapidly expanding technology and economy. The immediate future appears to be rich in the assurance of an incredible growth and development as to make the progress to now seem dilatory. Medicine has kept the pace—even at times has led in the parade of achievement.

What of the future?

Does the medical profession have any plan or plans for its role in this bright tomorrow? Who will determine medicine's place? If our profession has any plans for the future, they are the best kept secret of the age. Industry has known the need for planning for the future for decades. They spend considerable sums upon research in this field and budget this money as investment. Governmental agencies also plan for the future. Not too high a titre of prescience is needed to suspect that labor unions are active in future planning.

Because no man can predict the future, shall no man plan ahead? This argument denies the validity of education. Education is the best means of preparing for the future. Alas, a well educated man is not always a well prepared man. Are our medical schools equipping the doctor of medicine of tomorrow as adequately as can be, *or need be?*

Our noble profession is heavily occupied in caring for existing matters that are often of an emergency nature. The assertion that we are resistive to change falls flat, especially in the field of technique and therapy. Here our passion for the 'new' makes the fickle style swings in women's clothes appear pedestrian. When the matter is economic, social or political, *then* we are resistive to change. Yet our environment is made up of these factors—and when the sands shift a bit we tend to use our heads like the ostrich. And so in 1968 or 1978 the expensively educated and well-trained doctor of medicine might not be deciding whether to use drug A or drug B. His will be the complex decision as to whether the dose should be 0.02 or 0.03 milligrams. You and I received a torch from our predecessors. Is it to be a stick without a spark that we pass on to our successor?
—RALPH A. JOHNSON, *Detroit Medical News*, Feb. 10, 1958.

Annual Reports

ANNUAL REPORT OF IODIZED SALT COMMITTEE—1957-1958

A meeting of the Iodized Salt Committee was held on December 16, 1957.

Mr. William J. Burns, Executive Director of the MSMS, reported on his meeting with Mr. J. Hanley Wright of Chicago, the representative of the Salt Producers Association. The purpose of this meeting was to form plans for a new public campaign—another "Michigan First"—to re-emphasize the importance of using Iodized Salt.

Plans were made to release three or four reports on endemic goitre to the newspapers annually, and the salt manufacturers were also encouraged to advertise the use of iodized salt.

Report on Movie.—Dr. R. L. Waggoner and Dr. R. C. Moehlig reported on the progress of their movie which is to be shown at schools, PTA groups, et cetera. Dr. Moehlig is translating some of the German experience with iodized salt and this is being incorporated into our movie.

A communication from the National Committee of U. S. Public Health Service from Dr. O. P. Kimball was read and discussed.

A vigorous educational program was decided upon to stress again the Iodized Salt story. TV shows over the University of Michigan station, placards at the MCI, a paper on the MSMS Postgraduate Medical Education program, and talks at the 1959 Michigan Rural Health Conference and the 1960 Rural Health Conference, were decided upon.

The State Health Commissioner and his staff were commended for their efforts in public education regarding salt-containing iodine.

We believe that we are continuing in the right direction by putting into effect this vigorous program as outlined. A summer meeting of our Committee and the Salt Producers Association has been scheduled.

Respectfully submitted,

B. E. Brush, M.D., *Chairman*
H. A. Towsley, M.D., *Vice Chairman*
L. A. Berg, M.D.
J. B. Blodgett, M.D.
J. R. Carney, M.D.
R. C. Moehlig, M.D.
R. L. Rapport, M.D.
R. L. Waggoner, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY—1957-1958

The Advisory Committee to the Michigan State Medical Assistants Society has had two formal meetings. In Ann Arbor, November 25, 1957, and in Lansing, April 13, 1958.

In Ann Arbor we met with the officers and the Educational Committee of the Michigan State Medical Assistants Society, together with representatives of the Extension Department of the University of Michigan. As a direct result of this meeting, Dr. Ralph Steffek of the University of Michigan's Extension Department, organized an educational program which started in February, 1958, and will continue for three years. This is an ambitious type of "night school" program, and is the first of its kind in the United States, which is a complete course while still working. Through the efforts of the committee and an application from the University of Michigan, the Kellogg Foundation of Battle Creek has granted the University $7,200 to develop the course syllabi being used, which will enable textbooks to be printed and allow the course to be given by any college. In September of 1958, the courses will be given by the University of Michigan in six centers: Lansing, Flint, Pontiac, Detroit, Jackson, and Battle Creek.

In Lansing, April 13, 1958, we met in conjunction with the Board of Michigan State Medical Assistants Society at their spring Presidents Conference. Your committee feels that many members of the state society are not acquainted with the Michigan State Medical Society sponsored Medical Assistants organization. We feel that a continuing program should be undertaken by this Advisory Committee to make the MSMS members realize that MSMAS is a good organization which will return benefits to the individual physician, if his assistant belongs and participates.

We suggested to the Board of MSMAS, that since they have no central office and no executive secretary, the Detroit office of the MSMS might help them in clerical work and in maintaining better communications, both with their own members as well as with MSMS—if this activity meets with the approval of the State Medical Society.

We feel that the MSMAS is having organizational and growing pains, and we strongly recommend that the future advisory committees of the MSMS meet with the MSMAS Executive Board as often as possible to sincerely help these girls with their problems.

Respectfully submitted,

J. W. Rice, M.D., *Chairman*
D. B. Johnson, M.D.
J. E. Manning, M.D.
E. R. Sherrin, M.D.
Ralph W. Shook, M.D.
T. J. Trapasso, M.D.
Otto van der Velde, M.D.
J. E. Webber, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1957-1958

This committee did not hold any formal meetings this year, as there were no matters which the Chairman felt were of sufficient magnitude to call a meeting of the entire committee.

Several matters were discussed with the President of the Auxiliary and the Chairman, and advice was offered.

The committee has been ready and willing to assist the Auxiliary at all times and wishes to express their thanks for the opportunity of serving.

Respectfully submitted,

E. H. Fuller, M.D., *Chairman*
A. B. Aldrich, M.D.
J. S. Rozan, M.D.
D. A. Young, M.D.

ANNUAL REPORT OF THE CANCER CONTROL COMMITTEE, MICHIGAN STATE MEDICAL SOCIETY—1957-1958

This committee has held no meetings during the year because no items have been submitted.

All problems relating to cancer have been studied by The Cancer Coordinating Committee on which there are representatives from the Michigan State Medical Society. This is an active committee engaged in over-all cancer activities.

In the interest of efficiency, the elimination of the Cancer Committee, Michigan State Medical Society, is recommended.

Respectfully submitted,

MILTON A. DARLING, M.D., *Chairman*
J. W. HUBLY, M.D.
F. W. BALD, M.D.
R. E. CARLSON, M.D.
E. I. CARR, M.D.
F. C. CRETSINGER, M.D.
R. J. FORTNER, M.D.
J. H. FYVIE, M.D.
L. E. HOLLY, M.D.
C. N. HOYT, M.D.
MR. D. E. JOHNSON
H. M. NELSON, M.D.
R. E. OLSEN, M.D.
H. M. POLLARD, M.D.
L. W. REUS, M.D.
E. M. WRIGHT, M.D.
W. A. HYLAND, M.D.

ANNUAL REPORT OF COMMITTEE ON MENTAL HEALTH—1957-1958

During the year ending May, 1958, the Committee on Mental Health held three general meetings. The Subcommittee for Definitions of Psychotherapy and Counseling was reactivated.

Members participated in the following meetings:

1. Fourth annual Conference of Mental Health Representatives of the State Medical Associations sponsored by the Council on Mental Health of the American Medical Association.
2. Preventive Medicine Committee Meeting of Michigan State Medical Society.
3. Meetings with Michigan Society of Neurology and Psychiatry.
4. Organizational Meeting of committee chairmen of Michigan State Medical Society.
5. Meetings of Planning Committee for the Conference on Rehabilitation held in May, 1958.

A number of mental health bills, which had been introduced in the State Legislature, were studied by the Committee. Conclusions on these bills were submitted for the information of the Legislative Committee.

The Committee studied and discussed the Bill concerning Certification of Psychologists which was introduced in the House of Representatives of the Michigan Legislature by the psychologists. The Committee again reaffirmed its position that psychologists should not be registered, or licensed by law, until problems are worked out regarding complete definitions as to the services to be rendered by psychologists. Members of the Committee appeared twice before the Executive Committee of the Michigan State Medical Society Council to clarify our position in this matter. Although the Certification Bill for psychologists died in committee, it is expected that it will be introduced again next year.

A member of the Committee was appointed as a member of the Liaison Committee of the Michigan Society of Neurology and Psychiatry to allow for a closer association of the two organizations.

A report was made by the Subcommittee on Addiction, concerning the problem of narcotic addiction in the City of Detroit. Our Committee felt that this matter should be kept under careful consideration.

The Committee assembled material on mental health for the October, 1957, issue of THE JOURNAL of the Michigan State Medical Society. Among this material were medical papers and an editorial concerning mental illness and mental health.

A member of the Committee testified before a Legislative Hearing on the Problem of sexual deviation.

One member of our Committee attended a Postgraduate Study which considered psychiatric problems in patients encountered in the general practitioner's office. The Committee decided we should take an active interest in programs of this nature.

The Chairman wishes to thank the Committee on Mental Health for their interest and support, and it is our hope that the activities of the Mental Health Committee have been of some assistance to the Michigan State Medical Society.

Respectfully submitted,

I. A. LACORE, M.D., *Chairman*
Z. S. BOHN, M.D., *Vice Chairman*
C. P. BARKER, M.D.
H. W. BIRD, M.D.
P. N. BROWN, M.D.
W. E. CLARK, M.D.
R. O. CREAGER, M.D.
J. M. DORSEY, M.D.
N. A. FLEISHMANN, M.D.
T. J. HELDT, M.D.
L. N. HERSHEY, M.D.
L. E. HIMLER, M.D.
W. T. HYSLOP, M.D.
R. A. JAARSMA, M.D.
R. F. KERNKAMP, M.D.
M. H. MARKS, M.D.
F. O. MEISTER, M.D.
C. J. MUMBY, M.D.
W. H. OBENAUF, M.D.
R. W. WAGGONER, M.D.
H. B. ZEMMER, M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE—1957-1958

A wide variety of activities was undertaken by the numerous advisory committees during the past year. While the individual detailed committee reports are published, a review of the high points in some of these is both informative and illustrative of the type of service rendered by these important committees.

The Tuberculosis Control Committee has been working steadily on the problem arising out of the decreased utilization of TB sanatorium beds; on the matter of radiation hazards that may arise in mass TB x-ray programs and the setting of a minimum age for participating children; and on legislation regarding recalcitrant tuberculosis patients.

The *Industrial Health Committee* reported that the industrial health situation was most pressing in the 25,000 small plants in the State partly because insurance carriers are interested mostly in traumatic conditions. It urged the appointment by county societies of committees on occupational medicine to aid in the solution of this and other problems.

The *Mental Health Committee* has had under consideration legislative matters related to the licensure of psychologists and the practice of psychotherapy by nonmedical personnel; and has studied a number of mental health bills introduced before the State Legislature.

Among the many questions before the *Child Welfare Committee* were those concerned with adoption procedures, poison control centers, anti-poliomyelitis vaccination and school health problems. The activities of this Committee are so extensive as to require the services of several sub-committees.

The *Geriatrics Committee* has continued its aggressive activities in the interest of the aged through conferences, study of the nursing home problem and a visit to Carmel Hall in Detroit.

The *Committee on Postgraduate Medical Education* constantly reviews the effectiveness and up-to-dateness of its teaching program, modifying and introducing changes aimed to inform and assist the practitioner in the field.

The *Iodized Salt Committee* continues its educational efforts in goitre prevention through movies, television, radio and conferences.

The *Maternal Health Committee* has under way the establishment of a maternal tissue registry and continues its valuable studies of maternal and infant mortality.

The *Rheumatic Fever Control Committee* has again awarded postgraduate fellowships to six physicians who will study at St. Francis Sanatorium in New York. In addition to its numerous activities, it has arranged for participation in Michigan Heart Association Wet Clinics.

The *Venereal Disease Control Committee* has arranged with the State Laboratories for administering the Treponema Pallidum Immobilization tests. It has also considered changes in the Premarital Law and has made a survey of mass blood testing and its results. The question of discontinuance of routine serologic tests by some hospitals is being investigated.

The *Preventive Medicine Committee* as a whole is taking steps to develop a Michigan Conference on Athletic Diseases during the coming year; and it has reviewed together with the State Health Commissioner, the latter's budget proposals for the coming year.

As may be seen from this brief summary, much ground has been covered and many problems attacked diligently. As always, Dr. A. E. Heustis, our State Health Commissioner, has participated helpfully in our deliberations for which we are deeply grateful.

Respectfully submitted,
WILLIAM S. REVENO, M.D., *Chairman*
I. A. LACORE, M.D.
B. E. BRUSH, M.D.
M. A. DARLING, M.D.
R. R. DEW, M.D.
S. T. HARRIS, M.D.
R. M. HEAVENRICH, M.D.
A. E. HEUSTIS, M.D.
F. A. JONES, JR., M.D.
D. F. KUDNER, M.D.
M. B. MEENGS, M.D.
A. H. PRICE, M.D.
W. B. PROTHRO, M.D.
R. L. RAPPORT, M.D.
J. M. SHELDON, M.D.
FRANK STILES, JR., M.D.
H. A. TOWSLEY, M.D.

ANNUAL REPORT OF THE MATERNAL HEALTH COMMITTEE—1957-1958

1. Our Maternal Health Committee had the first meeting at the Sheraton-Cadillac Hotel in November, 1957. The planned program was reviewed and sub-committees were appointed to: (a) continue the maternal mortality study and publication, (b) encourage maternal mortality programs and better relationships with county societies, (c) encourage adult education, (d) develop perinatal mortality studies. Efforts were to continue toward a tissue registry of all pathology encountered in maternal deaths.

2. The second meeting was held at the Lansing Country Club and the wives were invited. The sub-committees all offered reports and while progress is slow it was felt that we were definitely making progress. The Health Department showed an exhibit of fetal waste and Dr. Trescott showed slides and reviewed his subject of sex education that he gives to the Lansing schools. The tissue registry is now in operation at the University of Michigan. This February meeting was voted a success.

3. The third meeting is to be held in Saginaw, Michigan, on June 12. Clarence Toshach and his wife are entertaining the members of the Committee and their wives after the scientific meeting and dinner. The meeting is to review the work that Saginaw has done on perinatal mortality, emphasize the method used in evaluating maternal deaths, and summarize the work of the year.

As chairman of the Maternal Health Committee, I would like to comment that I believe the committee serves two functions: one is tangible and the other intangible. The first serves to promote an analysis of obstetrics, a study of maternal and perinatal mortality, promote medical and lay education and promote better public relationships. The intangible values arise from assembling interested obstetricians from different communities, discussing their community problems and possibly taking back to their community a new approach or a renewed interest and vigor.

Respectfully submitted,
F. A. JONES, JR., M.D., *Chairman*
H. A. OTT, M.D.
F. W. BALD, M.D.
C. A. BEHNEY, M.D.
C. M. BELL, M.D.
H. R. BRUKARDT, M.D.
GOLDIE B. CORNELIUSON, M.D.
A. L. FOLEY, M.D.
W. F. GOINS, M.D.
J. E. HARRYMAN, M.D.
E. F. HERSEY, M.D.
H. W. LONGYEAR, M.D.
A. G. MCQUAIG, M.D.
N. F. MILLER, M.D.
H. R. MOOI, M.D.
H. W. SILL, M.D.
P. S. SLOAN, M.D.
MARY C. STELLHORN, M.D.
C. S. STEVENSON, M.D.
P. E. SUTTON, M.D.
D. W. THORUP, M.D.
J. H. TISDEL, M.D.
KATHRYN D. WEBURG, M.D.
H. R. WILLIAMS, M.D.
MARY LOU BYRD, M.D., *Advisor*
J. V. FOPEANO, M.D., *Advisor*

ANNUAL REPORT OF TUBERCULOSIS CONTROL COMMITTEE—1957-1958

The Tuberculosis Control Committee met on January 8, 1958 and again on March 5, 1958. The following principle items were brought up for discussion:

Radiation Hazards.—The Committee recommended that survey chest x-rays not be done on children under the age of eighteen unless they had reacted positively to a tuberculin skin test.

Tuberculin Skin Testing.—The Committee recommended that there be more extensive use of tuberculin skin testing, particularly in children under eighteen, by general practitioners in the State of Michigan.

Case Finding.—The Committee recommended the following methods for increased case finding of tuberculosis: (1) tuberculosis skin testing, (2) mass x-ray of high incidence groups, (3) routine hospital admission x-rays, (4) industrial and pre-employment x-rays and (5) continuation of mass chest x-rays as currently being conducted throughout the state.

Utilization of Excess Tuberculosis Beds.—The Committee recommended that County Tuberculosis Sanatoria, with the approval of County Boards of Supervisors and in co-operation with County Medical Societies concerned, accept patients with certain chronic diseases as private patients to be managed by their own private physicians if so desired. Component County Medical Societies of MSMS were notified of this action through the Secretary's Letter.

There was little unanimity of opinion among committee members as how to best utilize excess tuberculosis beds. It was generally felt that the solution varied dependent upon the facility involved. No recommendation was made to The Council other than that each county medical society involved should interest itself in the local situation and work in cooperation with the county board of supervisors to solve this problem for each separate sanatorium.

A special committee to study utilization of vacant tuberculosis facilities was approved by the Executive Committee of The Council at its April 15, meeting and such a Committee was appointed by the Chairman of The Council. At the time this report was submitted this special committee had not met.

Legislation Regarding Tuberculosis Control.—House Bill 452 which proposed progressive closing of three State Tuberculosis Sanatoria was discussed. The Tuberculosis Control Committee was represented at an open hearing concerning this Bill on March 5, 1958 and presented a united front advising the House Committee that this action would remove activities of the State in tuberculosis control from three important areas. It was the feeling of those who attended the hearing that the House Committee reacted favorably toward these objections.

Senate Bill 1215 which proposed utilization of excess beds in State Sanatoria for purposes other than isolation and treatment of Tuberculosis was discussed at length. Representatives of the Tuberculosis Control Committee had met with the sponsors of this Bill and objected to the wording which suggested that the State of Michigan could enter into the private practice of medicine. The Committee recommended to The Council that Senate Bill 1215 be approved and supported with certain changes in the wording of the Bill to avoid this insinuation.

Home Treatment of Tuberculosis.—The Committee recommended to The Council that the portion of the State Health Department budget regarding home treatment of tuberculosis be approved. It should be noted that the vote on this motion was five to four with two members abstaining.

Journal MSMS.—The Committee requested that the November, 1959, issue of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY be allocated to the Tuberculosis Control Committee. This request was granted by Editor Haughey and activities have begun to organize contributions to this issue.

Respectfully submitted,

R. L. RAPPORT, M.D., *Chairman*
R. C. BATES, M.D.
ABRAHAM BECKER, M.D.
M. B. CONOVER, M.D.
W. N. DAVEY, M.D.
J. L. EGLE, M.D.
J. L. ISBISTER, M.D.
LOUIS JAFFE, M.D.
A. H. KEMPTER, M.D.
G. H. PHILLIPS, M.D.
R. A. RASMUSSEN, M.D.
A. F. STILLER, M.D.
C. J. STRINGER, M.D.
J. W. TOWEY, M.D.
JACK FOY WU, M.D.
S. A. YANNITELLI, M.D.
STEWART YNTEMA, M.D.
G. T. MCKEAN, M.D., *Advisor*

ANNUAL REPORT OF THE VENEREAL DISEASE CONTROL COMMITTEE—1957-1958

A meeting was held on March 13th, 1958, at which time a number of important matters were considered.

1. Dr. H. E. Cope reported that the Michigan Department of Health is now prepared to administer T.P.C.F. Tests, to aid in the evaluation of biologic false positive reactors to the standard serologic test. The suggested priorities were as follows:

(a) Those cases in which special medical dispensation for marriage is requested on the basis of probable biologic false positive reaction.

(b) Problem blood test taken in pregnancy, in which the physician believes there is a biologic false positive reaction or for which immediate treatment would be needed if the patient were actually infected with syphilis.

(c) Special problem cases submitted by physicians or health departments after being screened by a Venereal Disease Control Officer.

The committee complimented the Health Department for its fine work in introducing this test and moved that the availability and criteria used be published in THE JOURNAL of the Michigan State Medical Society, and the County Medical Society Bulletins. This information has been published in THE JOURNAL MSMS of April, 1958.

2. The reconsideration of a previous motion relating to the premarital laws, it being generally agreed that the present law works some hardships on patients who are no longer infectious. This matter was tabled after considerable discussion, but the committee voted to modify the rules relating to medical dispensations so that an individual who has had the infectious syphilis and has been adequately treated can be married as soon as an adequate decline in the blood titre is evident.

3. Consisted of a consideration of a further report by Dr. Cowan on the results of mass blood testing, wherein he showed that the greater use of mass blood testing would be an economic benefit by reduction of the number of cases of psychosis due to syphilis confined in mental hospitals in Michigan.

4. Concerns serologic testing and accreditation of hospitals. It was pointed out by members of the committee that some hospitals discontinued routine serologic tests and the committee moved that it be recommended to the Michigan Department of Health, that they survey the hospitals in Michigan on their routine hospital admission serologic policy and attempt to get information on the number of hospitals doing this routine test, and the results they are obtaining. It is hoped that this information will be used as a guide in future hospital policy.

A second meeting will be held in July, subsequent to the publishing of this report, and a supplementary report will be issued following the meeting.

Respectfully submitted,

FRANK STILES, JR., M.D., *Chairman*
V. W. CAMBRIDGE, M.D.
J. A. COWAN, M.D.
A. C. CURTIS, M.D.
R. H. GREKIN, M.D.
P. J. HETTLE, M.D.
H. L. KEIM, M.D.
L. W. SHAFFER, M.D.
H. C. TELLMAN, M.D.
KORNELIUS VANGOOR, M.D.
R. S. BREAKEY, M.D.

ANNUAL REPORT OF THE SCIENTIFIC RADIO COMMITTEE—1957-1958

During the current year, forty programs for lay education were tape-recorded and distributed in the state at weekly intervals over the following stations: WAGN, Menominee; WOAP, Owosso; WBRN, Big Rapids; WBFC, Fremont; WDET, Detroit; WBCK, Battle Creek; WKAR, East Lansing; WDBC, Escanaba; WLDM, Detroit; WIBM, Jackson; WMDN, Midland; WUOM, University of Michigan; WWBC, Flint, and WFUM, University of Michigan (Flint).

1. *Distribution and Advertising.*—This year for the first time in the history of the Scientific Radio Committee, the Radio Broadcasting System of the University of Michigan, under the direction of Mr. Edwin Burrows, prepared a brochure describing programs under the heading "Prescription for Health." These brochures were sent to every radio station in the State of Michigan. In addition, a letter was addressed to the president and secretary of every county medical society with the brochure enclosed, encouraging each county society to contact their local radio station for distribution of the

radio programs. These brochures were sent out late in November, 1957, and we are just beginning to receive additional requests from stations for these programs.

As a result of these efforts, two new stations were added to the chain distributing these recordings.

The committee would like to urge strongly that those physicians located in communities where the programs are not now being distributed make every effort to get these programs on the air for the coming year over their local stations.

2. *Programing.*—The general plan of preparation of the radio series has been altered for the current year. Instead of one speaker carrying the load as in previous years, attempts have been made with a number of the programs to have panel discussions as indicated in the summary sheet of the 1957-1958 Scientific Radio Series.

There has been an average of a little better than fifty requests per week for written copies of the talks given. These requests have been filled by the mailing service of the University Broadcasting System.

Arrangements have been made to provide continuous programs throughout the summer on the "Prescription for Health" series to those stations now carrying the programs. These are to be provided by the University using as talent members of the faculties of the School of Public Health, School of Nursing, School of Dentistry and School of Pharmacy. Several of the anticipated programs in this series will be directed to career activities. The regular program, "Prescription for Health," will resume in October, 1958.

Again this committee would like to call to the attention of members of the State Medical Society that tape recordings of these programs are available through the Public Relations Office of the State Society and that they may be obtained by any member of the Society for his own use or for the use in presentation of subjects to lay audiences. It is also suggested that any of the members of the State Society who are currently subscribers to the *Audio Digest* and have a tape recording device with playback could use these talks for source material if they are interested.

The committee regrets to report that one of its members, William L. Foster, M.D., died during this year.

Respectfully submitted,

HARRY A. TOWSLEY, M.D., *Chairman*
CARL B. BEEMAN, M.D.
S. J. BEHRMAN, M.D.
JOHN H. BUELL, M.D.
C. G. CALLANDER, M.D.
C. T. FLOTTE, M.D.
*WILLIAM L. FOSTER, M.D.
GORDON H. SCOTT, PH.D.
JOHN M. SHELDON, M.D.
R. WALLACE TEED, M.D.
KENNETH W. TOOTHAKER, M.D.

*Deceased

SCIENTIFIC RADIO SERIES—1957-1958

No.	*Date*	*Subject*	*Speaker*
10- 4-57	1	Psychological Aspects of Pregnancy-I	George Morley, M.D. Samuel Behrman, M.D.
10-11-57	2	Psychological Aspects of Pregnancy-II	Tommy Evans, M.D. Saul Harrison, M.D.
10-18-57	3	Asian Flu	F. Davenport, M.D.
10-25-57	4	The Impact of the New Baby in Your Home-I	George Lowrey, M.D. Stuart Finch, M.D.
11- 1-57	5	The Impact of the New Baby in Your Home-II	Samuel Behrman, M.D.
11- 8-57	6	The Poison Control Center	George Lowrey, M.D.
11-15-57	7	The Symptoms of Disease—Vomiting	Robert Bolt, M.D. Ernest Watson, M.D.
11-22-57	8	Auto Accident Control	Seward Miller, M.D. John Rodger, M.D.
11-29-57	9	The Symptoms of Disease—Abdominal Pain	Keith Henley, M.D. C. T. Flotte, M.D.
12- 6-57	10	The Symptoms of Disease—Diarrhea and Constipation	Daniel Hunter, MD. Norman Talner, M.D.
12-13-57	11	The Symptoms of Disease—Headache	Kenneth Magee, M.D. James Taren, M.D.
12-20-57	12	The Symptoms of Disease—Fever	Nancy Furstenberg, M.D.
12-27-57	13	Physical Fitness and Health Maintenance	Charles Tupper, M.D.
1- 3-58	14	Poliomyelitis-I	David Dickinson, M.D.
1-10-58	15	Poliomyelitis-II	David Dickinson, M.D.
1-17-58	16	Kidney Diseases-I	William Oliver, M.D.
1-24-58	17	Kidney Diseases-II	Ian Thompson, M.D.
1-31-58	18	Kidney Diseases-III	John Weller, M.D.
2- 7-58	19	Heart and Cardiovascular Disease-I	Franklin Johnston, M.D.
2-14-58	20	Heart and Cardiovascular Disease-II	Herbert Sloan, M.D.
2-21-58	21	Heart and Cardiovascular Disease-III	Aaron Stern, M.D.
2-28-58	22	Heart and Cardiovascular Disease-IV	Aaron Stern, M.D.
3- 7-58	23	Fads in Dieting	Miss Isabel Foster, Dietitian
3-14-58	24	Cholesteral—What is it?	David Streeten, M.D.
3-21-58	25	Concepts of Allergic Disease-I	John Sheldon, M.D.
3-28-58	26	Concepts of Allergic Disease-II	John Sheldon, M.D.
4- 4-58	27	Cancer-I	Duncan McLean, M.D.
4-11-58	28	Cancer-II	George Block, M.D.
4-18-58	29	Cancer-III	Thomas Flotte, M.D.
4-25-58	30	Cancer-IV	Daniel Hunter, M.D.
5- 2-58	31	Present Concepts of Medical Education	Robert Lovell, M.D.
5- 9-58	32	Mental Health-I	Stuart Finch, MD.
5-16-58	33	Mental Health-II	Philip Brown, M.D.
5-23-58	34	Arthritis and Allied Diseases-I	Ivan Duff, M.D. and Charles Denko, M.D.
5-30-58	35	Arthritis and Allied Diseases-II	Leonard Bender, M.D.
6- 6-58	36	Eye Disease—Cataracts, Glaucoma	F. Bruce Fralick, M.D.
6-13-58	37	Summer Allergies	Kenneth Mathews, M.D.
6-20-58	38	Skin Problems of the Adolescent	Dermatology Staff
6-27-58	39	Skin Problems of the Adult	Dermatology Staff

LAY MEDICINE DURING EARLY MIDDLE AGES

(Continued from Page 1007)

Notes

For other aspects of medieval medicine, see Gordon, B. L.: Medicine in the Koran, *The Journal of the Medical Society of New Jersey,* October 1955, vol. 52, pp. 513-519; and Gordon, B. L.: Arabian Medicine in the Post-Koranic Period, *The Journal of the Michigan State Medical Society,* vol. 55:1109-1116 (Sept.) 1956.

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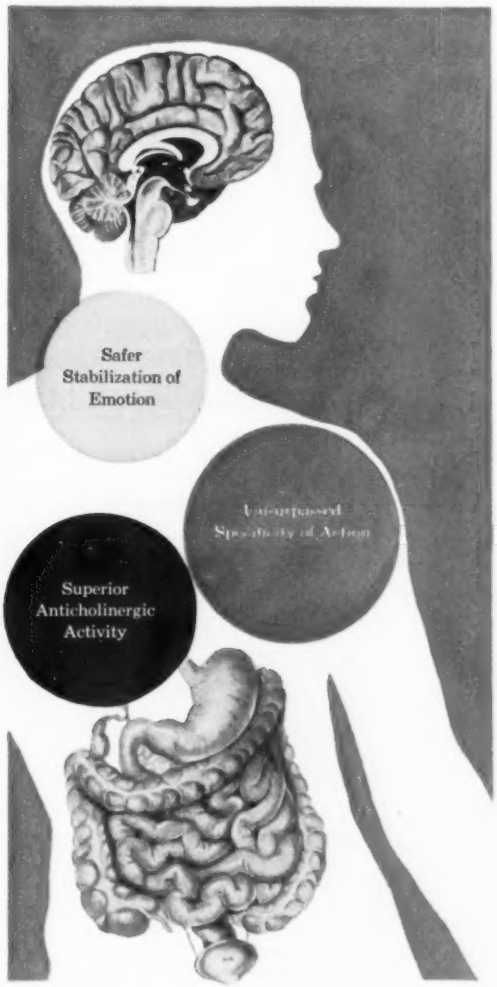

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Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

POLICIES OF THE MICHIGAN DEPARTMENT OF HEALTH RELATIVE TO HOSPITAL INFECTIONS

In order that the Michigan Department of Health may give all possible assistance to hospitals manifesting outbreaks of infections, the following plan for co-ordinating services within the Department has been developed:

Personnel from the following divisions will participate in the investigation and control of the infections on request:

Division of Disease Control, Records and Statistics
- The Chief of the Section of Acute Communicable Disease

Division of Maternal and Child Health
- The Chief of the Section of Hospital Consultation and Licensing
- The Nursing Consultants of this Section
- The Sanitary Engineers assigned to this Section from the Division of Engineering

Division of Laboratories
- The Co-ordinating Physician and bacteriologists

The plan is as follows:

1. The first visit to follow-up on a request for consultation with reference to a suspected hospital infection problem will be made by the Chief of the Acute Communicable Disease Section, or his designated representative.
2. Since each situation is likely to differ, the procedure to be followed will be determined at the time of the first visit.
3. Other department personnel involved will be directly responsible to the physician in charge (Chief of the Acute Communicable Disease Section) and available on his request.
4. All reports, findings, and recommendations will clear through the physician in charge (Chief of the Section of Acute Communicable Disease) before release.
5. The physician in charge (Chief of the Section of Acute Communicable Disease) will keep all interested persons involved informed as early as convenient.
6. Requests will be honored from both the hospital and the local health department. If the request originates with the hospital, the local health department will be informed.
7. All releases of information to the public will ordinarily be the sole responsibility of the hospital administrator. Exceptions to this policy will be made only by the State Health Commissioner.

Franking Privilege Withdrawn

In the past to facilitate and expedite the collection of vital records, and communicable disease morbidity reports, the federal government has allowed state and local health departments the use of penalty mail (franking privilege). However, as of July 1, 1958, this privilege has been withdrawn and, as a result, physicians are no longer permitted to use postcards, envelopes or labels carrying the franking privilege for sending case reports of communicable disease to either the local or the state health departments.

All full-time local health officers in Michigan have been instructed to pick up all such postcards, envelopes or labels so that they cannot be used after June 30, 1958. Methods of collecting communicable disease morbidity records in local areas will have to be worked out by the local health officers so that communicable disease reporting by private physicians can be maintained at the current level.

The state health department will supply local registars of vital records and local health officers with business reply labels which they can use in transmitting vital records and communicable disease morbidity reports to the Michigan Department of Health.

In Memoriam

CHARLES S. BALLARD, M.D., seventy-nine, Detroit eye, ear, nose and throat specialist, died May 17, 1958. Dr. Ballard was a Detroit area resident for 34 years. He was a native of Kansas. Memberships included Acacia Lodge, F. and A.M., and the Riverside Kiwanis Club.

CHARLES W. BRAYMAN, M.D., Cedar Springs physician, died May 1, 1958.

A native of Custer, Michigan, Dr. Brayman moved to Ludington as a child and graduated from the Ludington High School, after which time he came to Grand Rapids Medical College. He graduated from medical school in 1902 and came to Cedar Springs where he established his practice.

A leader in community affairs, Dr. Brayman was honored as the "Citizen of the Year" in 1949. He was charter member and past president of the Cedar Springs Rotary Club. He also served on the village council and was chairman of the cemetery board for many years.

Dr. Brayman was a Life Member of the Kent County Medical Society.

NEAL J. McCANN, M.D., fifty-eight, former Marquette physician, passed away recently in California, according to a belated notice just received. Dr. McCann was born in Tacoma, Washington, July 1, 1899. He acquired a pharmaceutical degree from Creighton University before taking his medical education at Loyola University, Chicago, a member of the class of 1927. Dr. McCann began his practice in Ishpeming, Michigan, in 1933, moving to Marquette in 1945. In 1951, he moved to Torrance, California, where he practiced until his retirement due to illness in 1955.

Dr. McCann was very active in the medical field. He was a past president of the Upper Peninsula Medical Society.

DAN R. HERKIMER, M.D., sixty-two, Lincoln Park physician, died May 14, 1958. A native of Maybee, Michigan, he attended Eastern Michigan College and the University of Michigan before enrolling in Wayne University College of Medicine. He earned his medical degree in 1926 and came to Lincoln Park the following year.

In 1930, he was named City Health Officer, a post he held continuously until the United States entered the second world war. Dr. Herkimer had served in the Navy in World War I, and in 1942, he re-entered active service as a lieutenant-commander in the Navy Reserve. After the war, he remained in the reserve, and in 1952 was elevated to the rank of captain.

Dr. Herkimer was a member of Wayne County Medical Society, Michigan State Medical Society, the American College of Surgeons, Detroit Athletic Club, Military Order of World Wars and the Lincoln Park Post, American Legion.

MAX STEINER, M.D., fifty-one, Detroit physician, died April 29, 1958. Dr. Steiner was graduate of the Wayne University College of Medicine, class of 1934. He served in the U. S. Army in World War II, as a captain. He was a member of the Wayne County Medical Society, Maimonides Medical Society, Phi Lambda Kappa Medical Fraternity and a Diplomate of the American Board of Psychiatry.

JOSEPH WADDINGTON, M.D., ninety-three, Detroit physician, died May 11, 1958. Dr. Waddington was one of Detroit's oldest practicing physicians. His yen to travel carried him to nearly every foreign land. In the last seven years, he made seven trips around the world. He had planned to visit Tahiti next month. Dr. Waddington was born in Manchester, England, coming to the United States in 1884, and was a graduate of the Indiana College of Medicine.

RANDALL A. WHINNERY, M.D., forty-six, a Grosse Pointe Park physician, died May 27, 1958.

Dr. Whinnery was on the staffs of Harper and Florence Crittendon hospitals and had been assistant chief of staff of the McGregor Health Foundation since 1945.

He was a fellow of the American College of Physicians and a member of the American Board of Internal Medicine, as well as a member of other medical groups and of the Detroit Boat Club.

TV JINGLES PLUG GOOD HEALTH

Well-known nursery rhyme characters like Humpty Dumpty and Jack and Jill helped to sell the idea of healthful living to many American families during 1957. Some fifty-four counties in twenty-six states sponsored the AMA's twenty-second animated cartoon health spots last year, reports the Bureau of Health Education. These jingles were shown over local television stations in such metropolitan areas as Los Angeles, Denver, San Francisco, Miami, Chicago, Louisville, Detroit, Kansas City, Tulsa, Cincinnati, Providence, Memphis, Milwaukee and Houston. Health subjects covered in the ten-program series include treatment of colds, road safety, isolation, careful use of pointed toys, cold prevention, first aid, long life, diet, balanced meals and food preservation.

Each set of spots is "personalized" with the name of the county or state medical society on both the visual and auditory film track. The series still is available to local medical societies—at no charge—by requesting order blanks from the Bureau of Health Education.

Hospital practice of infant feeding

Standard formulas for FEEDING REGULATION

Underfeeding is a common cause when infants fail to gain and thrive. In the earliest stage, when caloric intake is inadequate, the infant cries after feeding, remains constipated, and the restlessness from hunger is mistaken for colic. A changed or weakened formula appears to be indicated.

But clinical studies show that a young infant requires a formula of 2 ounces of whole milk (40 calories), a teaspoon of Karo Syrup (15 calories), and a half-ounce of added water *per pound of body weight per day*. Of the total calories, a successful formula yields about 15-20% in protein, 50-60% in carbohydrate, and 25-35% in fat. Whole milk must be reinforced by adding 5% to 10% carbohydrate (1) to provide protein-sparing effect which permits protein anabolism instead of energy production; (2) sufficient calories for tissue formation; (3) proper utilization of fat; (4) suitable acid-base relationships in the intestinal tract and (5) adequate weight gains.

WHOLE MILK FORMULAS

Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812

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Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

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MICHIGAN AUTHORS

Fred Holtz, M.D., and **Lewis A. Schmidt, III, M.D.,** Ann Arbor, are the authors of an article entitled, "Lymphoid Polyps (Benign Lymphoma) of The Rectum and Anus," published in *Surgery, Gynecology and Obstetrics,* June, 1958.

Robert I. McClaughry, M.D., Detroit, is the author of an article entitled, "Responsibility of Hospitals in Graduate Medical Education," read before the Association of Hospital Directors on Medical Education, Chicago, February 8, 1958, and published in the *Journal of the American Medical Association,* May 31, 1958.

Arthur C. Curtis, M.D., and **Donald S. Schuster, M.D.,** Ann Arbor, are the authors of an article entitled, "The Laboratory Diagnosis, Biology, and Treatment of Latent Syphilis," read before the Eleventh International Congress of Dermatology, Stockholm, July 31, 1957, and published in the *Journal of the American Medical Association,* May 31, 1958.

Frederick C. Swartz, M.D., F.A.C.P., Lansing, is the author of an article entitled, "Medical Education for Gerontology," published in the *Maryland State Medical Journal,* April, 1958.

John W. Keyes, M.D., and **Franz J. Berlacher, M.D.,** Detroit, are the authors of an article entitled, "Chlorothiazide (Diuril) A New Non-Mercurial Oral Diuretic," published in *Henry Ford Hospital Medical Bulletin,* March, 1958.

John R. Caldwell, M.D., and **Roy J. Karjala, M.D.,** Detroit, are the authors of an article entitled, "Chlorothiazide As An Adjunct in the Treatment of Hypertensive Cardiovascular Disease," published in *Henry Ford Hospital Bulletin,* March, 1958.

C. P. Hodgkinson, M.D., Detroit, is the author of an article entitled, "Effect of Violent Exercise on Fibrinogen Level," published in the *Henry Ford Hospital Medical Bulletin,* March, 1958.

John S. DeTar, M.D., Milan, is the author of an article entitled, "The Generalist and the Specialist," published in the *Pennsylvania Medical Journal,* May, 1958.

Robert N. Lehmann, M.D., Cameron Morrison, M.D., Alvin Rutner, M.D., Charles J. Koucky, M.D., and **Gerald S. Wilson, M.D.,** Detroit, are the authors of an article entitled, "Cancer of the Stomach," read at the sixty-fifth annual meeting of the Western Surgical Association, Salt Lake City, November 21, 1957, and published in *A.M.A. Archives of Surgery,* May, 1958.

Leonard P. Heath, M.D., Detroit, is the author of an article entitled, "Delayed Post-Partum Hemorrhage," presented at the twenty-fourth annual meeting of the Central Association of Obstetricians and Gynecologists, October, 1956, New Orleans, Louisiana, and at the sixty-first annual meeting of the Sioux Valley Medical Association, February, 1957, Sioux City, Iowa, and published in the *South Dakota Journal of Medicine and Pharmacy,* May, 1958.

E. S. Gurdjian, M.D., J. E. Webster, M.D., W. G. Hardy, M.D., and **D. Lindner, M.D.,** Detroit, are the authors of an article entitled, "Surgical Considerations in the Management of Cerebrovascular Disease," presented at the Symposium of Peripheral Vascular Disease co-sponsored by the Minnesota Heart Association and the Mayo Foundation, Rochester, Minnesota, September 25, 1957, and published in *Minnesota Medicine,* May, 1958.

C. Byron Landis, M.D., Ann Arbor, is the author of an article entitled, "Experience with Cyclodiathermy at the University of Michigan," published in *University of Michigan Medical Bulletin,* April, 1958.

Darrell A. Campbell, M.D., Ann Arbor, is the author of an article entitled, "A Historic Case of Cynanche Trachealis," published in the *University of Michigan Medical Bulletin,* April, 1958.

Saul Sugar, M.D., Detroit, is the author of an article entitled, "Diagnosis of the Commoner Glaucomas," published in the *Journal of the International College of Surgeons,* and digested in *Digest of Ophthalmology and Otolaryngology,* January, 1958.

Wallace W. Tourtellotte, Ph.D., M.D., Russell N. DeJong, M.D., and **Wiecher H. Van Houten, M.D.,** Ann Arbor (now of Groningen, The Netherlands), are the authors of an article entitled, "A Study of Lipids in the Cerebrospinal Fluid. I. The Historical Aspects," published in the *University of Michigan Medical Bulletin,* March, 1958.

Thomas T. Callaghan, M.D., Detroit, is the author of an article entitled, "Pancreatic Pseudocysts," read before the Detroit Academy of Medicine, November, 1957, and published in *Harper Hospital Bulletin,* March-April, 1958.

Kenneth Ranney, M.D., and **Byron Berglund, M.D.,** Detroit, are the authors of an article entitled, "Fetal Salvage from Cesarean Sections at Harper Hospital," published in *Harper Hospital Bulletin,* March-April, 1958.

Jan Nyboer, D.Sc., M.D., and **Rodney Willard, M.D.,** Detroit, are the authors of an article entitled, "I. Initial Ultra-Frequency Ballistocardiographic Complexes in

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Major Arterial Obstruction—Case Report," published in *Harper Hospital Bulletin*, March-April, 1958.

Jan Nyboer, D.Sc., M.D., Detroit, is the author of the following articles, "II. Comparison of Ultra-Frequency and Direct Ballistocardiograms" and "III. Constant Mass Ultra-Frequency Ballistocardiograms—Family Series" published in *Harper Hospital Bulletin*, March-April, 1958.

Raymond Mellinger, M.D., Bernard Therian, Ph.D., Irene T. Kline, Ph.D., John Ditzler, M.D., Roger Smith, M.D., and **Gerald Fine, M.D.**, Detroit, are the authors of an article entitled, "Primary Aldosteronism —Department of Medicine—Symposium," published in *Henry Ford Hospital Medical Bulletin*, March, 1958.

J. Reimer Wolter, M.D., Ann Arbor, is the author of an article entitled, "Secondary Degeneration of the Human Retina," published in *A.M.A. Archives of Ophthalmology*, May, 1958.

* * *

M. K. Newman, M.D., Detroit, delivered an address at the Annual Meeting of the Muscular Dystrophy Association of America, Toledo, Ohio, at the Toledo Academy of Medicine on May 21, 1958. The title of the talk was, "The Functions of a Muscular Dystrophy Clinic, and General Management of the Muscular Dystrophy Patient."

* * *

Carcinogenic Factors.—Traffic problems and air pollution of large cities are not factors causing cancer, according to a University of Michigan surgeon, who summarized the latest information on this disease in a recent radio interview.

Daniel C. Hunter, M.D., of the University's Department of Surgery, related that a statistical study of New York City showed the same incidence of cancer there as in agricultural areas.

Dr. Hunter said that smokers seem to be involved in the problem of cancer. "The tobacco industry objects to the claim that cigarettes have anything to do with cancer," he stated. However, it appears that heavy smoking can cause coughing or bronchitis. "This is a point of irritation and with chronic irritation we may expect a certain number of cancers will be involved," he said.

One in every seven persons become involved with some type of cancer, Dr. Hunter explained. The specific cause is unknown, but researchers are aware that some types arise from cells present during the development of the fetus. According to this theory, these remain in a resting state until they receive a stimulus to growth and become malignant. It also has been shown that there are certain inherited conditions which may develop into cancer, although the factor of heredity is not a prominent one.

Other research noted by the surgeon was that in certain areas of the world, where highly seasoned foods are eaten, there is an increased number of stomach cancers while lung cancer is fairly common in a region of the

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Austrian Alps where cobalt is mined. Irritation thus seems to be a significant factor in the disease, he emphasized.

The radio program, "Prescription for Health," was produced by U-M Broadcasting Service and was heard on FM stations, WUOM, Ann Arbor, and WFUM, Flint. William Stegath, WUOM production director, was host for the program, which will be re-broadcast throughout the state.

* * *

The Department of Health, Education, and Welfare announces that in June there will be published the third annual volume of the *Bibliography of Medical Reviews*. Review articles listed in Volume 1 and 2 were gathered as a by-product of the *Current List of Medical Literature* operation. Volume 3, however, extends its collection of review articles to all of the current journals received by the National Library of Medicine. Copies of Volume 3 for 1958 will be available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., at a price presently estimated at $1.25.

* * *

E. J. Hammer, M.D., Grosse Pointe Park, Michigan, has just returned from Davos-Parsenn, Switzerland, where he was one of three American speakers on the program of the Third International Congress of Skiing Traumatology and Winter Medicine. The subject of his paper was, "Ski Injuries in the United States. Their Causes and Prevention."

* * *

Charles A. Neafie, M.D., Pontiac, who for forty years has been a Health Officer in Pontiac, received on May 8, 1958, from the Michigan Health Officers Association Conference in Detroit, a Distinguished Health Service Award. Dr. Neafie is a past secretary and president of the Oakland County Medical Society. He is also a former member of the Council of the Michigan State Medical Society. The Michigan Health Officers Association also made Dr. Neafie "President for a Day" of the Michigan Health Officers Association.

* * *

The Coller-Penberthy Medical Conference will be held in Traverse City, Michigan, on Thursday and Friday, July 24 and 25, 1958 at the Park Place Hotel.

* * *

The American Otorhinologic Society for Plastic Surgery will have a meeting at Mexico City and Acapulco, February 15 through 30, 1959; also a meeting at the Conrad Hilton Hotel, Chicago, on October 12, 1958.

* * *

Prize Essay from Wayne.—One of the most distinguished honors for senior medical students has been won by a Wayne State University College of Medicine senior. Daniel S. Elman was named first place winner of the tenth annual Senior Medical Student Prize Essay Contest of the New England Journal of Medicine. His prize was $150 and publication of his paper in

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the JOURNAL sometime this summer. His topic was "Familial Association of Nerve Deafness with Nodular Goiter and Thyroid Carcinoma."

Elman is the son of Mr. and Mrs. Abraham Elman, Detroit. While studying for his B.A. degree at Wayne State, he was elected to Phi Beta Kappa. He will intern at Sinai Hospital following graduation in June.

* * *

John S. DeTar, M.D., Milan, was one of the speakers at the 1958 Annual Meeting of the State Medical Society of Wisconsin, held in Milwaukee on May 6, 7 and 8. His topic was "Cancer Detection in the Office of the Generalist." Dr. DeTar is past president of the American Academy of General Practice.

* * *

Northeastern Surgical Conference.—The fourth annual Northwestern regional meeting of the International College of Surgeons will be held in the Equinox House, Manchester, Vermont, June 30 through July 5.

The scientific program will include a paper to be presented by Earl Carl, M.D., of Lansing, Michigan, entitled, "The Surgeon's Role in Traffic Liabilities."

* * *

The Detroit Surgical Society announces the new officers and Council members for 1958 as follows: past president, Wm. S. Carpenter, M.D.; president, D. W. McLean, M.D.; president-elect, John Reed Brown, M.D.; secretary, Edward M. Vardon, M.D.; treasurer, Edward J. Shumaker, M.D.; audit control officer, Donald N. Sweeney, Jr., M.D.; Council: Harry C. Saltzein, M.D.; Fred G. Hicks, M.D.; Alfred M. Large, M.D.; Charles E. Darling, M.D., and Raphael Altman, M.D.

* * *

Leonard K. Eaton, assistant professor in the College of Architecture and Design, has issued a book entitled "New England Hospitals 1790-1833," published by the University of Michigan Press. In 1790, few New Englanders had ever seen a hospital. Professor Eaton says:

"Today when the relations of the hospital to the state and to society at large are the subject of much discussion in the press, on the radio and on television . . . In this early period the hospital was, as it is in our time, an institution devoted to healing the sick, a center of research and administrative struggle and growth."

* * *

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part I, and requests for re-examination Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1958. No applications can be accepted after that date. It should be noted by prospective candidates that the deadline date will be August 1, in 1959.

Candidates are requested to write to the office of the Secretary for a current Bulletin if they have not done so in order that they might be well informed as to the present requirements. Application fees

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($35.00), photographs, and lists of hospital admissions must accompany all applications, and should be addressed to ROBERT L. FAULKNER, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

The United States Atomic Energy Commission on June 4, announced the awarding of sixty-one unclassified physical research contracts to colleges, universities and private research institutions. The contracts total $3,508,555. Seven are new and the remaining fifty-four are for continuation of research already under way.

The contracts are awarded as a part of the Commission's continuing policy to assist and foster research related to atomic energy. Research costs usually are shared by the institutions and the Commission.

Five of the contracts were awarded to the University of Michigan as follows: (1) "Low Temperature Chemical Thermodynamics," E. F. Westrum, Jr., $18,950, (2) "Polarographic Behavior of Organic Compounds," P. J. Elving, $17,025, (3) "Experiments on the G-Factor of the Free Electron and the Polarization of Electrons in Scattering," R. W. Ridd, $27,300, (4) "Nuclear Research with 300 mev Synchrotron," R. W. Ridd, $48.800 and (5) "Fundamental Research on Isotope Reactions," R. B. Bernstein, $30.000.

The Werle-Bennett graduate fellowship has been established by the Michigan Tuberculosis Association to encourage careers in the fields of tuberculosis and public health and to provide opportunities for advanced training in these fields. The grant provides up to $2,500, including one year's tuition, for the selected applicant.

Requirements for application include Michigan residence, a bachelor's degree from a recognized college or university, eligibility for admission to the University of Michigan School of Public Health, and a desire to continue in the field of TB or public health after graduation. Application forms are obtainable from the Michigan Tuberculosis Association, 403 Seymour Avenue, Lansing 14, Michigan.

The annual fellowship was adopted in a resolution of the Board of Trustees in recognition of the leadership of Theodore J. Werle, retired MTA Executive Secretary, and Harry D. Bennett, MTA treasurer, for the past thirty-six years.

MICHIGAN TUBERCULOSIS ASSOCIATION

* * *

Small Pox Eradication.—The USSR claims to have wiped out smallpox, according to their delegation at the World Health Assembly in Minneapolis. WHO,

World Health Organization, has listed smallpox to have top priority on global elimination. There have been no cases of smallpox reported since 1954 in the United States or any Central American republic. The disease continues to be a problem in five South American countries.

* * *

Polio Vaccine.—The American Medical Association, the National Foundation for Infantile Paralysis and the United States Public Health Service, are again urging to the public that every person under forty be vaccinated against polio. All three shots are recommended. To date, May 23, 49 millions have received the full course of three injections and 46.5 million have received none. President Eisenhower has "heartily endorsed" this program. Polio is another disease which could be eliminated.

* * *

Military Internships.—During the Fiscal year, 1959, which begins July 1, 1958, a total of 178 Army interns, representing sixty-seven medical schools throughout the United States, will begin a one-year rotating type internship at ten Army hospitals. In addition to the varied clinical material available to Army interns at each of the hospitals, the Army's newest constructed hospitals at Fort Bragg, North Carolina and Fort Benning, Georgia, exemplify the most recent technical and architectural advancements.

Army intern training provides each intern with an exceptional opportunity to obtain experience and professional growth. The program has been designed to meet all requirements of the Council on Medical Education and Hospitals of the American Medical Association.

Following is a list of the Michigan students:

Fitzsimons Army Hospital, Denver, Colorado; Neill S. Cooper, Jr., RFD No. 3, Plattsburg, New York, University of Michigan; Letterman Army Hospital, Presidio of San Francisco, California; John H. Reed, Jr., 22913 Colony, St. Clair Shores, Michigan, Wayne State University; U. S. Army Hospital, Ft. Benning, Georgia; John E. Wygmans, 123 East Elm Street, Lansing, Michigan, University of Michigan; U. S. Army Hospital, Ft. Bragg, N. C.; Richard A. Pollard, 809 Lawrence Street, Ann Arbor, Michigan, University of Michigan.

* * *

Drug Advertising.—The Federal Trade Commission has issued orders prohibiting three well-advertised makers of proprietary remedies from representing that certain of their products are effective treatments for arthritis, rheumatism and related diseases. The companies involved are the manufacturers of "Omega Oil," "Mentholatum Deep Heat Rub," "Infra Rub" and "Heet." Advertising claims for relief of minor aches are permitted, but representations that the oils, salves,

et cetera, have any beneficial effect below the skin surface are forbidden. *WRMS*, May 19, 1958.

* * *

"Swimmer's Itch."—The Michigan Department of Health and the University of Michigan Museum of Zoology have combined efforts in a battle against snails carrying parasites which cause "swimmer's itch." This is very common in the Upper Peninsula but has appeared also on the beaches of the Lower Peninsula. There are two problems evident: (1) biological research on the mollusk vectors and (2) extermination of the snail. The infection in Egypt has been most severe for many years. There, humans carry the larvae worms, but ducks and birds deposit the eggs in water, the snails are the carriers and the larvae burrow under the skin causing an intensly uncomfortable rash.

It is hoped that the University of Michigan research will further the search for a remedy.

* * *

McGregor Memorial Conference Center.—Wayne State University, on Sunday, May 18, 1958, opened the doors of the new McGregor Conference Center to help highlight the University's ninetieth Alumni Reunion weekend. This building, a gift of the McGregor Foundation, has been under construction since December, 1956. The white marble building was designed by Detroit architect, Minoru Yamasaki (the same man the Michigan State Medical Society has engaged to design its new Headquarters Building).

The McGregor Center is the third of four buildings comprising the Community Arts Block. Already in use are the Music and Arts Buildings, while the combination Auditorium, Alumni House and President's home is still under construction.

* * *

The AMA PR Doctor Bulletin for May, has a box on page 6 reading as follows:

The Mediation Committee of the Wayne County (Detroit) Medical Society found that *fee complaints are less likely to arise from the size of the fee than from the doctor's failure to explain his services.* Out of fifty-six grievance committee cases, only three stemmed from the patients' belief that the fees themselves were unreasonable. Half of the total cases were settled by a simple explanation of what the physician had done to warrant the charge. "How much more satisfactory if the explanations had come from the physician rather than the committee," concluded Dr. Luther Leader, committee chairman.

* * *

New Internal Revenue Ruling.—Physicians who are full-time employes of hospitals are subject to a new ruling by the Internal Revenue Department. Where the patient writes a check to the doctor direct, the doctor may endorse it over to the hospital and thus may be excused from including the sum as income. He must attach a schedule of his tax return setting forth sources of the fees, amounts received and disposition thereof.

* * *

Medicare Costs (May, 1958).—The appropriations committee of the House of Representatives reported that as a result of their investigation of Medicare,

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maternity cases were the most popular Medicare service and they averaged $224. Respiratory infections averaged $164, and appendectomies averaged $335. In maternity cases, the costs between the hospital and the doctor were almost equal. Costs of processing claims ranged from $3 to more than $11 per claim.

* * *

Utilization.—There was a 35 per cent increase in the average patient load of service men's dependents in military and civilian hospitals in 1957 as compared to the same period of 1956.

* * *

The Michigan State Society of Clinical Hypnosis will be organized as a branch of the American Society of Clinical Hypnosis at a meeting on Tuesday, September 30, Sheraton-Cadillac Hotel, Detroit, 7:30 p.m. All physicians who use hypnosis in their practice, those interested in doing so, and other M.D.'s desirous of joining the Society, will be welcomed. Reservations may be made by contacting Ralph V. August, M.D., 72 East Broadway, Muskegon Heights, Michigan.

* * *

The Academy of Psychosomatic Medicine will hold its fifth annual meeting at the Park Sheraton Hotel, New York, October 9-11, 1958. For program and information write Bertram B. Moss, M.D., 1035-55 East Washington Street, Chicago 2, Illinois.

What They said About the 1958 Michigan Clinical Institute:

M. J. Franzblau, M.D., University of California Hospital, San Francisco (guest): "As a native of Michigan I was justly proud of the program presented at your Michigan Clinical Institute. The amount of planning that went into the production of the conference was most evident. It is always nice to return home and I hope to participate in your future programs, soon and frequently."

* * *

Anthony T. Wachna, M.D., Windsor, Ontario, (guest): "Once again the Michigan Clinical Institute was excellent and greatly appreciated. Personally I should like to express my appreciation of the hospitality of your Society and hope that we in Ontario can reciprocate in similar manner."

* * *

Ford Motor Company has constructed two new medical units at its Rouge Plant, to replace the thirty-two-year-old hospital in the "B" building. The first Rouge Hospital was established in 1918 in a farm house purchased with the land when the Rouge was being built. The original staff was composed of four physicians and one extern.

The two new units have a combined floor space of 24,700 square feet with fifty-four separate rooms for examination, et cetera, in addition to doctors' offices, waiting rooms and all other standard facilities for emergency treatment. A staff of thirteen physicians and one

dentist, as well as registered nurses, first aid attendants and laboratory technicians are manning the two new hospitals.

* * *

Gordon B. Myers, M.D., Detroit, has been appointed head of the new Wayne State University Service in Internal Medicine at Harper Hospital, Detroit.

* * *

Jerome W. Conn, M.D., Ann Arbor, presented the Banting Memorial Lecture at the 18th Annual Meeting of the American Diabetes Association in San Francisco on June 21. The lecture is named in honor of Sir Frederick G. Banting, co-discoverer of insulin. Dr. Conn's presentation was titled "The Pre-Diabetic State in Man: Definition, Interpretation and Implication."

* * *

The American College of Obstetricians and Gynecologists invites all residents in hospitals to prepare original papers on either clinical or research material, to win the College Award including presentation of the winning paper at its French Lick meeting of September 25 to 27, 1958. Deadline date is September 1. Manuscripts may be forwarded to Charles F. Gillespie, M.D., 3400 N. Meridian St., Indianapolis 8, Indiana.

* * *

The Michigan Proctologic Society elected the following officers for the current year: President Joseph W. Becker, M.D., Detroit; President-elect Donald J. Pearson, M.D., Battle Creek; Secretary Guy W. Deboer, M.D., Grand Rapids; Treasurer Martin C. Sharp, M.D., Saginaw.

The Cyrus C. Sturgis Internists Club has elected H. M. Pollard, M.D., and Robert J. Bolt, M.D., Ann Arbor, as executive vice president and secretary-treasurer, respectively.

The club consists of doctors throughout the United States who have trained in internal medicine at the University of Michigan; they meet annually during the national assembly of the American College of Physicians.

* * *

A. D. Ruedemann, Sr., M.D., Detroit, has been elected president of the Detroit Ophthalmological Society.

* * *

"M.D. International" and "Monganga," the two latest March of Medicine television reports on the work of American physicians have been selected for presentation at the Brussels World Fair by the World Fair Film Selection Committee of which Charles F. Schwep is chairman. Both of these medical documentaries were produced and sponsored by Smith Kline & French Laboratories of Philadelphia in co-operation with the American Medical Association.

* * *

Dr. Simon Levin, Houghton, was honored by the Houghton Rotary Club on May 3 "for his great worth to the community over many years of sacrificing service."

Congratulations, Doctor Levin!

* * *

Retrospective diagnoses of historical personalities, as viewed by leading contemporary psychiatrists, are contained in an interesting brochure just released by Schering Corporation of Bloomfield, New Jersey. Diagnoses

in modern terms on the basis of known historical data are made of Nero, Cesare Borgia, Genghis Khan, Rasputin, John Wilkes Booth, Catherine the Great, Cagliostro and Robespierre. The diagnoses make interesting reading.

* * *

The Arthritis and Rheumatism Foundation offers predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1959. Deadline for application is October 31, 1958. Predoctoral fellowships stipends range from $1500 to $3000 per year; postdoctoral fellowships from $4000 to $6000 per year; senior investigator awards from $6000 to $7500 per year tenable for five years. For full information write the Medical Director of the Foundation at 10 Columbus Circle, New York 19, New York.

* * *

Fredrick A. Coller, M.D., Cyrus C. Sturgis, M.D., and **Ruth C. Wanstrom, M.D.,** were honored at a testimonial dinner in Ann Arbor on June 10 when 237 members of the Medical School Faculty and guests recognized their many years of service to the University of Michigan and to Medicine. Scrolls were presented to these three retiring members of the medical school faculty; addresses were made by University President Harlan Hatcher, Regent C. S. Kennedy, M.D., and Dean A. C. Furstenberg, M.D.

CORRECTION

The picture on page 643 of the May issue of THE JOURNAL which is labelled as that of Dr. Julius Bauer of Los Angeles, California, is actually that of Dr. William Dameshek of Boston, Massachusetts. The Editor regrets this error and wishes to thank the several very observant persons who called this to his attention.

CORRECTION

In the News Medical section of the May issue of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, through some error the name of the senior author was omitted. This notification should have read: "Stephen J. Figiel, M.D., Leo S. Figiel, M.D., and Desmond K. Rush, M.D., of Detroit, are the authors of an original article entitled, 'Study of the Colon by Use of High Kilovoltage Spot Compression Techniques,' which was published in *The Journal of the American Medical Association,* March 15, 1958. This paper was presented before the section of Radiology at the 106th Annual Meeting of the American Medical Association in New York in June, 1957, by the senior author, Stephen J. Figiel."

MEDICAL TELEVISION SHOWS

Shows produced by Michigan Health Council over WJBK-TV, Detroit: May 4—Nutrition (Film—"Food Facts and Fads"); May 11—Career in Pharmacy (Guests: Stephen Wilson, Dean, Marilyn Houck and John Van Blarcom, University of Michigan Students, and Don Hall of Kalamazoo); May 18—Emergency Care (Film—"Hospital Emergency Care").

Legal Opinion

Dear Dr. Secretary:

At the request of the Council of the Michigan State Medical Society, I have given attention to the matters raised in your letter of March 7, 1958, and the attached correspondence.

As I understand the matter, the basic facts are as follows. The doctor is requested to interpret electrocardiograms for a laboratory which is largely owned and wholly directed by nonmedical individuals. The doctor would be paid a set fee for each interpretation and the reports would be sent to the physician requesting the examination on the stationery of the laboratory. The patients would be billed by the laboratory and, presumably, the laboratory would profit to the extent of the difference between the fee paid by it to the doctor and the fee charged by it to the patient. I understand further that there is no direct medical supervision with respect to any of the procedures of the laboratory which is operated on a purely commercial basis.

In my opinion, the suggested procedure would be unethical on the part of the doctor. Prior to the recent revision of the Principles of Medical Ethics of the American Medical Association, Section 5 of Chapter VII of the Principles read as follows:

> "A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

Although, under the Statement of Principles as revised in 1957, the above quoted specific language does not appear. I think it was not intended that any different view be taken of the lack of propriety existing in the purveyal of medical service under circumstances which permit exploitation of the services of a physician to the financial profit of a lay organization.

Whether or not the proposed practice might be said to be illegal as distinguished from the ethical question involved is, at least, doubtful. The Medical Practice Act of Michigan provides that the Board of Registration in Medicine may refuse to issue or may revoke a certificate of registration for "unprofessional and dishonest conduct" as defined in the Act. Among the defined acts of unprofessional conduct is "connection with, or lending one's name to, an illegal practitioner of medicine." Whether the lay agency involved would be regarded as practicing medicine under the circumstances above outlined, is at least questionable and, while I do not express the opinion that illegal practice is involved, it is my opinion that, under the circumstances set forth, the suggested procedure would be of doubtful legality.

LESTER P. DODD
Legal Counsel

Lansing, Michigan
April 15, 1958

THE DOCTOR'S LIBRARY

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE HEBREW MEDICAL JOURNAL Semi-annual publication, Moses Einhorn, M.D., Editor. Volume I and II, 1957 (Anniversary Year). The Hebrew Medical Journal, 983 Park Avenue, New York 28, New York.

The *Hebrew Medical Journal* this year is celebrating its Thirtieth anniversary of continuous publication. It is written in Hebrew with English summaries, the journal has played an important part in the creation of a medical literature and terminology in the language of the Bible. The journal is now issued in two volumes for the year, books of approximately 200 pages containing very well presented, well selected articles.

THE CHANGING PATIENT-DOCTOR RELATIONSHIP. Martin G. Vorhaus, M.D., F.A.C.P. Drawings by A. Birnbaum. New York: Horizon Press. Price, $3.95.

The problem of presenting to the lay reader the complexities of the diagnosis and treatment of psychosomatic illness in simple everyday terms, is a challenge not easily denied. In this book, the approach is one of analysis of the patient-physician relationship with the

avowed intent of bringing about better rapport and greater satisfaction in both the patient groups and the doctor groups.

This analysis is presented in chapters entitled: "The Patient—How he became one," "The Patient—What he was before he became one," "The Doctor—Why he became one," and "The Doctor—Builder of Bridges." These chapters include comments, examples, and many direct quotations that will be familiar and interesting to the practicing physician. Though the case histories of duodenal ulcer, colitis, hypertension, and obesity are almost too simple, they are interesting and informative. Many physicians will enjoy this book.

F.O.M.

CLINICAL OBSTETRICS AND GYNECOLOGY. Volume 1, Number 1. Management of Endocrine Problems. Edited by Allan C. Barnes, M.D.; Medical Problems in Pregnancy. Edited by Curtis J. Lund, M.D. New York: Paul B. Hoeber, Inc. (Harper & Brothers), March, 1958.

This book embodies a new approach to the subject of obstetrics and gynecology. This is the first in a series of four issues per year—two subjects per issue, one on gynecology and one on obstetrics. This first issue is concerned with the medical complications in pregnancy in which each subject is written by a different individual who has had special clinical experience in this field. The second part of this first issue is a symposium on the management of endocrine problems.

The main value in a book of this kind is the combination of the didactic with the practical. It is very easy reading and holds one's interest throughout the subject. This book should be included in all libraries because of its value not only as a standard textbook, but also as a reference book on these subjects.

J.R.P.

YOU CAN INCREASE YOUR HEART-POWER. By Peter J. Steincrohn, M.D., F.A.C.P. Garden City, New York: Doubleday & Company, Inc. 1958. Price $4.95.

This is a different type of "heart book" written for the lay reader by the author of a nationally syndicated medical column. It embodies advice for the lay reader on matters cardiac based on the central theme of what the author calls conservation of "heart power."

Using a homey conversational style the author discusses the common types of heart disease, related vascular disease, and their underlying causes, manifestations and management. Full use is made of the question and answer type of presentation along with interesting anecdotes and uncomplicated exposition. Each section is followed by a summary of the highlights of the material just covered.

The readability of this book is a particular recommendation to the inquiring layman concerned with obtaining a knowledge of his heart and related subjects, of diseases of the heart and circulation, and of the reasons for the various measures advised in their treatment. The importance of prevention of heart disease is stressed and although some of the advice may vary from that of other well recognized authorities in certain details, it nevertheless measures up to common sense standards. The author emphasizes the importance of obtaining a good physician and following his advice.

R.W.B.

DIABETES AS A WAY OF LIFE. By T. S. Danowski, M.D., Renziehausen Professor of Research Medicine, University of Pittsburgh School of Medicine; Senior Staff Physician at Presbyterian-Woman's Children's, Elizabeth Steel Magee, and Shadyside Hospitals of Pittsburgh; Consulant in Metabolism, Oakland Veterans Administration Hospital, Pittsburgh. New York: Coward-McCann, Inc. Price $3.50.

Dr. Danowski presents a readable, informative, and useful up-to-date guide for the diabetic patient in this small volume of less than 200 well written pages.

This little handbook has evolved from an extensive clinical experience at the University of Pittsburgh Medical Center. Diet, food values, types of insulin, methods of insulin administration, and diabetic control in health and illness are clearly dealt with. Factual information regarding the nature of the disease and how the diabetic can cope with the various problems arising in his daily living are well set forth.

This volume is good reading which the busy physician will do well to recommend to his diabetic patients. It will encourage better control through more intelligent and effective patient cooperation.

R.W.B.

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YOUNG PHYSICIAN completing military service desires temporary position with practitioner or group from November 1, 1958 until June 1, 1959. Graduate Indiana University, internship Receiving Hospital, Detroit. General experience in medicine, obstetrics, pediatrics on specialized services during military tour. Address inquiries to John Tedford, M.D., 5746 Arnold, Tucson, Arizona.

GENERAL PRACTITIONER—Aged 30, married, military service completed, desires a free partnership or association in Michigan. Will consider solo practice. Contact: Box 11, 606 Townsend Street, Lansing, Michigan.

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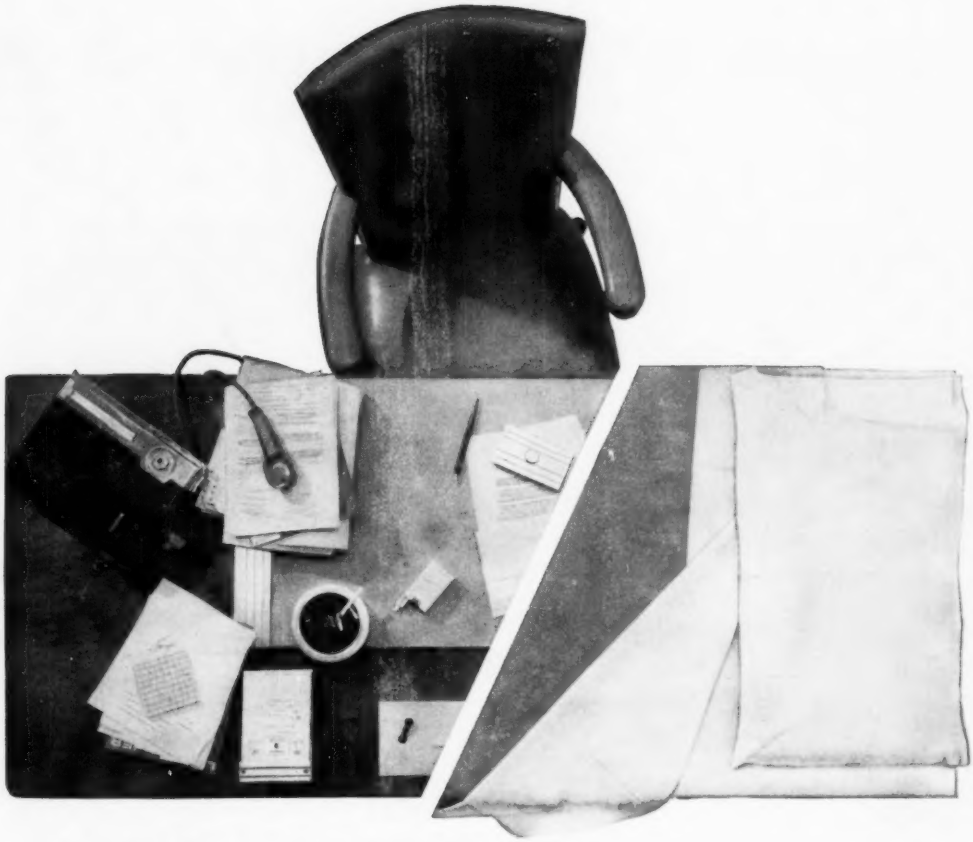

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